



STATE OF TENNESSEE  
 EMPLOYEE SICK LEAVE BANK  
 FIRST FLOOR, JAMES K. POLK BUILDING  
 505 DEADERICK STREET  
 NASHVILLE, TENNESSEE 37243-0635  
 TEL. (615) 741-5431 1-800-221-SEIL (7345)  
 FAX (615) 532-3209

**SICK LEAVE BANK MEDICAL CERTIFICATION**

**COMPLETED FORM MUST BE MAILED OR FAXED BY THE MEDICAL OFFICE DIRECTLY TO THE SICK LEAVE BANK AT THE ADDRESS ABOVE**

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Sick Leave Bank to make all necessary investigations concerning this application. I further authorize the release of any records or information, including but not limited to medical, Workers' Compensation, State Retirement, or Social Security disability that is sought in connection with this application.

\_\_\_\_\_

**Patient's Name and SSN (Please Print)** **Patient's Signature (or legal representative)**

**Name of Medical Doctor/Surgeon (Please Print):** \_\_\_\_\_

**Part I: Initial Form: Part I and Part II (Entire Form) completed by the medical doctor/surgeon only.**

**1. HISTORY (Please answer all questions.)**

- (a) When did symptoms first appear or accident happen?..... Mo. \_\_\_\_ Day \_\_\_\_ Yr. \_\_\_\_
  - (b) Is this a work-related injury or illness with the state?..... Yes \_\_\_\_ No \_\_\_\_
  - (c) Is this a work-related injury or illness with another employer?..... Yes \_\_\_\_ No \_\_\_\_
- If yes, name, address, and telephone number of the non-state employer.**
- \_\_\_\_\_

- (d) Has patient ever had the same or a similar condition?..... Yes \_\_\_\_ No \_\_\_\_
- If yes, state when and describe.**
- \_\_\_\_\_

- (e) Was the patient referred to you by another medical doctor/surgeon? ..... Yes \_\_\_\_ No \_\_\_\_
- If yes, list the referring medical doctor/surgeon's name and telephone number.**
- \_\_\_\_\_

**2. PRESENT CONDITION (Please answer all questions.)**

- (a) Is patient's present condition the same condition or related to, resulting from, or recurring from a previously diagnosed condition for which he/she previously received treatment? ..... Yes \_\_\_\_ No \_\_\_\_
- If yes, what condition and/or diagnosis?** \_\_\_\_\_
- (b) For the present condition, was the patient: **Hospitalized?**..... Yes \_\_\_\_ No \_\_\_\_
- Had Surgery?** Yes \_\_\_\_ No \_\_\_\_ **If yes to either, please list all dates.**
- \_\_\_\_\_

**REQUIRED: Patient's Name and SSN (Please print):** \_\_\_\_\_

**Part II: For follow-up visits: Part II completed by the medical doctor/surgeon or nurse practitioner/physician's assistant.**

**3. DIAGNOSIS (Be specific – Please provide the ICD-9 code(s) and a written description.):**

Primary diagnosis: \_\_\_\_\_  
ICD-9 Description

Secondary diagnosis: \_\_\_\_\_  
ICD-9 Description

**4. TREATMENT (Please describe the treatment):** \_\_\_\_\_  
\_\_\_\_\_

**5. APPOINTMENT INFORMATION: (Current Condition)**

- (a) Date of first visit for this condition?..... Mo. \_\_\_\_ Day \_\_\_\_ Yr. \_\_\_\_
- (b) Date of next visit?..... Mo. \_\_\_\_ Day \_\_\_\_ Yr. \_\_\_\_
- (c) Was patient seen today? Yes \_\_\_\_ No \_\_\_\_ **If no:** Date of last visit?..... Mo. \_\_\_\_ Day \_\_\_\_ Yr. \_\_\_\_

**6. EXTENT OF DISABILITY FOR PATIENT'S REGULAR OCCUPATION:**

- (a) What is the usual recovery period for this condition? \_\_\_\_\_
- (b) Is the patient temporarily unable to perform any duties of his/her job?..... Yes \_\_\_\_ No \_\_\_\_  
**If yes,** beginning date: \_\_\_\_\_ ending date: \_\_\_\_\_  
**If no,** when was patient able to return to work?..... Mo. \_\_\_\_ Day \_\_\_\_ Yr. \_\_\_\_
- (c) When will the patient be able to return to work **with** restrictions?  
Approximate Date: \_\_\_\_\_ Indefinite: \_\_\_\_\_ Never: \_\_\_\_\_
- (d) When will patient be able to return to work **without** restrictions?  
Approximate Date: \_\_\_\_\_ Indefinite: \_\_\_\_\_ Never: \_\_\_\_\_

**The first Medical Certification Form (initial form for this condition) completed for this patient requires the signature of a Medical Doctor/Surgeon.  
Forms based on follow-up visits to your office require the signature of a Medical Doctor/Surgeon or a Nurse Practitioner/Physician's Assistant.**

I hereby certify that the above information is true and correct and that the information provided is objective medical information relative to this patient's application to the Sick Leave Bank.

**PLEASE PRINT:**

Name: \_\_\_\_\_  
Medical Doctor/Surgeon Signature and Title

Address: \_\_\_\_\_

Address: \_\_\_\_\_  
Date

Telephone #: (\_\_\_\_) \_\_\_\_\_

Fax #: (\_\_\_\_) \_\_\_\_\_