



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

- (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 the **present condition** the same or a similar condition or a condition related to, resulting from, or recurring from a **previously diagnosed condition**? ..... Yes \_\_\_\_ No \_\_\_\_  
**If yes**, please check the appropriate box(es) and provide previous condition/diagnosis and dates.  
 Same Condition: \_\_\_\_ Similar Condition: \_\_\_\_ Related to: \_\_\_\_ Resulting from: \_\_\_\_ Recurring from: \_\_\_\_  
**Describe previous condition/diagnosis and list date(s):** \_\_\_\_\_

- (b) For the **present condition**, was the patient: **Hospitalized**? ..... Yes \_\_\_\_ No \_\_\_\_  
**If yes**, please **list hospitalization dates**. \_\_\_\_\_

- (c) For the **present condition**, did the patient have surgery? ..... Yes \_\_\_\_ No \_\_\_\_  
**If yes**, please **list surgery dates**. \_\_\_\_\_

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

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

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3. **DIAGNOSIS - Current medical condition(s) preventing employee from performing the duties of his/her job. (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 - May include office visit, date of surgery, or hospital visit)**

(a) Date of visit for this completed form:..... Mo. \_\_\_\_ Day \_\_\_\_ Yr. \_\_\_\_  
(b) Date of next visit:..... Mo. \_\_\_\_ Day \_\_\_\_ Yr. \_\_\_\_

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

(a) Is the patient temporarily medically unable to perform any duties of his/her job?..... Yes \_\_\_\_ No \_\_\_\_  
**If yes**, beginning date: \_\_\_\_\_ ending date: \_\_\_\_\_  
(b) When will the patient medically be able to return to work **with** restrictions?  
Approximate Date: \_\_\_\_\_ Indefinite: \_\_\_\_\_ Never: \_\_\_\_  
(c) When will the patient medically be able to return to work **without** restrictions?  
Approximate Date: \_\_\_\_\_ Indefinite: \_\_\_\_\_ Never: \_\_\_\_  
(d) What is the usual recovery period for this condition? \_\_\_\_\_  
(e) Did the patient require additional recovery time due to complications for this condition? Yes \_\_\_\_ No \_\_\_\_  
**If yes**, please explain: \_\_\_\_\_

**The first Medical Certification form (initial form for this condition) requires the signature of the medical doctor/surgeon. Forms based on follow-up visits require the signature of the 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 Name and Title Signature and Title

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

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

\_\_\_\_\_  
Date

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

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