Tennessee Sex Offender Treatment Board

Physician Certification in Support of Medical Excuse Request

****Please type or print legibly. Forms that are not clear will not be accepted****

Patient Name: ____

Physician Name: ____

Practice Name and Address: ___________________________________

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Physician License Number: ______________ Office Phone: _______________

The above-named patient is currently experiencing a medical condition that substantially impairs the patient's ability to attend and participate in in-person sexual offender treatment. The nature of this condition prevents the patient from leaving home to attend work or other routine activities within the community. (Please describe the patient's condition):

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Is the patient's condition likely to improve with time, such that the patient may eventually be medically able to leave the home weekly to participate in treatment? YES / NO

I certify, under penalty of perjury, that the above is true and accurate to the best of my knowledge and belief, within a reasonable degree of medical certainty.

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Physician Signature

____

Date

TSOTB Form #001