TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
220 FRENCH LANDING DRIVE,
NASHVILLE, TENNESSEE 37243

Request for Information - Medical Statement

Claimant Name: _____ Claimant SSN: _____

Authorization to release information

I, _____, authorize the release of information pertaining to my medical history to the Tennessee Department of Labor & Workforce Development (TDLWD).

Signature: _____ Date: _____/_____/_____

To Physician: The above named individual has filed a claim for unemployment benefits.
TN Employment Security law requires that a claimant be physically able to work. Please provide the following information:

1. What date did you consider the patient unable to work? _____/_____/_____
2. Is the patient able to work at the present time? _____/_____/_____
3. What date did you release the patient to as able to return to work? _____/_____/_____
4. In your opinion, is the patient able to perform his/her usual work? ____ Yes ____ No
   If no, to what type of work is the patient restricted? _____
5. Did the patient resign from his/her last employment on your advice? ____ Yes ____ No
6. Was the patient's illness affected by his/her work? ____ Yes ____ No
   If yes, did the conditions: ____ Cause the illness, ____ Aggravate the illness, ____ Worsen the illness
7. Was the patient's illness affected by a change in his/her working conditions? ____ Yes ____ No
   If yes, did the conditions: ____ Cause the illness, ____ Aggravate the illness, ____ Worsen the illness
8. If the patient is expecting a child, what is the expected date of birth? _____/_____/_____
9. If the work this individual was performing or was referred to as deemed, in your opinion, to be clearly hazardous to the health of the individual, please certify as to the specific hazards posted to the patient's health by the job: _____
   _____
   _____.

COVID-19 Information:

Patient is excused from work until _____/_____/_____ due to (check all that apply):

___ Patient has been diagnosed with Covid-19, and has not been released from my care;

___ Patient has been advised by health care provider to self-quarantine due to Covid-19;

___ Patient should not return to work due to pre-existing health issue(s) that heighten the paient's risk of contracting Covid-19.

Physician's Name (Please print): _____ Date: _____/_____/_____

Physician's Signature: _____

Physician's Address: _____

_____

Physician's Phone Number: _____