



Filed Date Stamp Here

MEDICAL RECORD CERTIFICATION

Tennessee Division of Workers' Compensation
220 French Landing Drive
Nashville, TN 37243
Facsimile: 615-253-2480

www.tn.gov/labor-wfd/wcomp.shtml
wc.courtclerk@tn.gov
1-800-332-2667

Docket #: _____

State File #/YR: _____

RFA #: _____

Date of Injury: _____

SSN: _____

MEDICAL RECORD CERTIFICATION

Employee

Employer and Carrier

Pursuant to Rule 0800-02-21.16(2)(b), the undersigned

- medical provider
- custodian of the records

certifies that the attached medical records of _____ are true and accurate.
(name of medical provider)

Signature

Printed Name

Date