TENNESSEE SEX OFFENDER TREATMENT BOARD

Physician Certification in Support of Medical Excuse

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

Patient Name: _____

Physician Name: _____

Practice or Clinic Name:_____

Address of Practice/Clinic:_____

Physician License Number: _____ Office Phone: _____

The above-named patient has a statutory and court obligation to participate in in-person treatment. They are requesting a medical waiver due to a serious or debilitating medical condition. In order to receive this waiver, the condition needs to restrict their movements or cognitive functioning to the point of being homebound, requiring home health assistance, and/or they are undergoing time-consuming or challenging treatment for the condition that causes limitations to their ability to perform necessary tasks and participate in general daily activities.

Patient's Full Diagnosis and Symptoms:

_____

_____

Patient's Prognosis :

_____

_____

_____

Current Medical Restrictions:

_____

_____

_____

Please describe the patient's current treatment plan including physical therapy and/or medication (specifically state the actions required for the patient to be able to resume normal activities):

_____

_____

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_____

Is the patient compliant with the plan of treatment? YES / NO

Is the patient bedridden or on bed rest? YES / NO

If YES, does the client have a home health aide? YES / NO

Is the patient restricted from leaving the home? YES / NO

Does the patient require an assisted device for mobility YES / NO

If YES, list the assisted device_____

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

If YES, what is the anticipated timeframe in which the offender would be able to resume treatment? _____

If you are certifying a condition that limits their statutory and court obligation, you must attach supporting documentation of the condition.

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.

_____ _____

Physician Signature **Print Name**

_____

Date