STATE OF TENNESSEE
DEPARTMENT OF HUMAN RESOURCES
TECHNICAL SERVICES DIVISION
SECOND FLOOR, JAMES K. POLK BUILDING
505 DEADERICK STREET
NASHVILLE, TENNESSEE 37243-0635
TEL: (615) 741-5595 FAX: (615) 401-7685

MEDICAL STATEMENT FOR THE TRANSFER OF DONATED SICK LEAVE

COMPLETED FORM MUST BE MAILED OR FAXED BY THE MEDICAL OFFICE DIRECTLY TO THE TECHNICAL SERVICES DIVISION AT THE ADDRESS ABOVE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Technical Services Division of the Department of Human Resources to make all necessary investigations concerning this application. I further authorize the release of any records or information, including but not limited to medical, 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): _____

Form may be completed by the medical doctor/surgeon or nurse practitioner/physician's assistant.

1. 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. _____

2. 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

3. 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?
   Approximate Date: _____ Indefinite: _____ Never: _____

Forms 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 for the transfer of sick leave.

PLEASE PRINT:

Name: _____ _____
Medical Doctor/Surgeon Name and Title **Signature and Title**
Address: _____
Address: _____ _____
Telephone #: (_____)_____ **Date**
Fax #: (_____)_____