**SICK LEAVE BANK MEDICAL FORM**
**Department of Human Resources – Employee Relations**
910 Madison Avenue, Suite 764 | Memphis, TN 38163 | 901.448.5600

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER

# Certification of Physician or Practitioner

## Employee Information

Name: _____

Position Title: _____ DOB: _____

## Physician's Statement

1). Diagnosis (Illness or Injury):_____

2). Date condition commenced:_____

3). What are the employee's current restrictions:_____

_____

_____

_____

4). Anticipated date employee will be able to return to work: _____

5). If you cannot determine when the employee can return, when will the employee be reevaluated: _____

_____

6.) Regimen of treatment to be prescribed. Indicate general nature and duration of treatment, including referral to other providers of health services. Include a schedule of visits or treatment.

_____

_____

_____

## Signature

Signature of Physician or Practitioner: _____ Date: _____

Print Name: _____

Type of Practice (Field of Specialization, if any): _____

Address of Physician or Practitioner: _____

Physician's Phone Number: (_____)_____ Physician's Fax Number: (_____)_____

**RETURN FORM TO HUMAN RESOURCES**
910 Madison Avenue, Suite 764
Fax: 901.448.8481
Email: bmarti75@uthsc.edu