City of Knoxville Pension System
Public Safety Complex
1650 Huron Street
Knoxville, TN 37917
Phone: (865) 215-7750
Fax: (865) 215-7758

Health Care Provider Certification Form

Instructions to the Health Care Provider: Your patient has made a claim for a disability pension benefit from the City of Knoxville Pension Board. Please answer fully and completely all applicable questions. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience and examination of the patient. Be as specific as you can; terms such as "unknown" or "indeterminate" may not be sufficient in determining this claim. Please limit your responses specifically to the claim for which the patient is requesting the disability. Please be sure to sign the form and provide your contact information.

Patient Name Requesting Benefit: _____

Provider's name and business address: _____

_____

Type of Practice/Medical specialty: _____

Telephone: ( ) _____ Fax: ( ) _____.

Name of Clerical/Medical Staff Assisting in the Preparation of this Form: _____

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

   _____No_____Yes. If so, dates and location of admission: _____
   _____

   Date(s) you treated the patient for condition: _____
   _____
   _____

   Will the patient need to have treatment visits at least twice per year due to the condition?
   _____No_____Yes

   Was medication, other than over-the-counter medication prescribed?_____No_____Yes

   If yes, please identify the medication(s) you have prescribed and the expected duration of the prescribed medication(s). _____
   _____
   _____

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist, surgeon, etc.)_____No_____Yes. If so, identify the health care provider(s) and state the nature of such treatments and expected duration of treatment: _____
   _____
   _____

2. Use the job specifications provided by the employer to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Please indicate whether you are using the employer provided job description or the employee's own description to answer these questions. _____Employer _____Employee

   Is the employee unable to perform any of his/her job functions due to this condition?_____No
   _____Yes

Question 2 continued on the next page

If so, identify the job functions the employee is unable to perform: _____
_____
_____
_____

Did you determine that the inability to perform the above duties was the result of a job related injury? _____No_____Yes

If yes, please identify the work related incident. _____
_____
_____

Does the employee's condition permanently prohibit the employee from performing these duties again?
_____No_____Yes

3. Have you determined whether the employee has reached maximum medical improvement?
_____No_____Yes

   If yes, please provide assessment information with this form._____
   _____
   _____

4. Have you performed a functional capacity exam? _____No_____Yes
   If yes, please provide exam documentation with this form._____
   _____
   _____

5. Describe other relevant medical facts, if any, related to the condition for which the employee seeks this disability benefit (such medical facts may be symptoms, diagnosis, or any regiment of continuing treatment such as the use of specialized equipment): _____
   _____
   _____

6. Will this condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?_____No_____Yes

   Is it medically necessary for the employee to be absent from work during the flare-ups?
   _____No_____Yes. If so, explain: _____
   _____

Question 6 continued on the next page

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency :_____times per_____week(s)_____month(s)
Duration :_____hours or _____day(s) per episode

I have read and verify that the information provided is accurate concerning the above-named patient:

Signature of Treating Physician:_____

Date:_____

RECEIVED AND ACKNOWLEDGED BY THE PENSION BOARD:

DATE: _____ BY: _____