Tennessee Technological University

Physician's Certificate of Total Disability

I, _____, M.D., am a physician practicing in the medical specialty of _____. I have examined (name of patient) _____ and do hereby certify that he/she suffers from the below described "permanent total disability that totally incapacitates the person from working at an occupation which brings the person an income" as defined in T.C.A., Section 49-7-113.

Description

_____

_____

_____

Physician Information

Physician Name (Print): _____

Physician Signature: _____

Date: _____

Return Instructions

In Person: 1 William L. Jones Drive, Derryberry Hall, Room 100

Mail: Bursar's Office, Box 5037, Cookeville, TN 38505-0001

Email: bursar@tntech.edu