Tennessee TECH

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:

_____

_____

_____

_____

_____ _____

Physician's Signature *Date*

Address: _____

_____

_____

_____

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*