THE UNIVERSITY OF TENNESSEE
HEALTH SCIENCE CENTER

GME Supplemental Leave Medical Certification Form

Section 1: Employee Information

Resident/Fellow Name: _____ **Personnel #:** _____

Program Name: _____ **PGY Level:** _____

A complete medical certification is required to determine whether your health condition or the health condition of your spouse, child, or parent qualifies for supplemental leave.

Section 2: Medical Provider Instructions

Instructions to Health Care Provider: Your patient or a family member of your patient has requested leave under the GME Supplemental Leave Program. Completion of this form is required for verification of eligibility for this leave benefit. Please complete section 3 of this form and return it to gme@uthsc.edu within 10 calendar days of receipt.

Section 3: Healthcare Provider Certification

Resident Name: _____

Patient's Name: _____

Relationship of patient to resident: Self ___ Spouse ___ Child ___ Parent ___ Other _____
Specify Relationship

Briefly describe the patient's medical condition, duration, and (if applicable) what care the resident can provide:

_____

_____

_____

_____

_____

_____

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_____

_____

_____

Name and Title of Healthcare provider: _____

Type of Practice: _____ **License Number & State:** _____

Address: _____

Telephone: _____ **Email and/or Fax:** _____

_____ _____

Healthcare Provider Signature **Date**

Section 4: Resident Certification:

Patient's Name: _____
Relationship to Resident: _____
NOTE: Please include expected birthdate if the requested leave is for the birth of your child.

RESIDENT SIGNATURE AND CERTIFICATION: I permit the University of Tennessee, Graduate Medical Education, or its designated health care provider or third-party administrator, to contact my health care provider or my family member's health care provider for purposes of obtaining clarifying information and authenticity of this medical certification, if necessary. I certify that the information contained herein is true and correct. I understand that leave will not be granted unless the Medical Certification form is completed by a competent healthcare provider and timely submitted to GME. This application is governed by the Professionalism Policy, GME Policy #125 and any misrepresentation or misuse of this time off may result in academic action due to unprofessional conduct and may be reported to future programs as an "unsatisfactory" for professionalism on the Summative Evaluation:

_____ _____
Resident Signature **Date**

If applicable, detail the type of care that you will provide for your family member:
_____

_____

_____

For GME Office Use Only:

Date Received: _____