To .he . ea.ing ph sician of _____

(Name of s.uden.)

_____

(Da.e of bi .h)

Pu suan. .o TCA § 49-7-113 Tennessee Tech Unive si. equi es a ea l ce .ifica.e f om a ph sician o an agenc cha ged wi.h compensa.ing .he disabled pe son o adjudica.ing .he pe manen. .o.al disabili. of .he pe son who is eques.ing admi..ance .o classes .ha. .he pe son is “pe manen.l .o.all disabled” as se. fo .h in TCA § 4-7-113. The . ea.ing ph sician o agenc mus. ce .if .ha. .he s.uden. mee.s .hese c i.e ia. The above named s.uden. is eques.ing a fee waive o discoun. unde .his p og am. If, in ou p ofessional opinion,

! "

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49-7-113. Disabled and elderly persons -- Auditing or enrollment.

CERTIFICATION OF PERMANENT, TOTAL DISABILITY

Student's (Patient's) Name _____

Student's (Patient's) Date of Birth _____

Date of Disability (when treating physician began treatment of student above _____

Date Disability ended or N/A if not applicable _____

As the treating physician for the above named individual, I do hereby certify as follows:

1. I have knowledge of the facts set forth hereinafter, which are true and correct to my personal and professional knowledge and belief.

2. I am the treating physician for the above named student and am aware of his/her medical condition.

3. _____ as a permanent, total disability that totally
(Name of Student/Patient)
Incapacitates the from working at any occupation which brings in/or an income.

Signature: _____ Date: _____

License Number of Treating Physician: _____

Office Phone: _____

Office Address: _____