|  |  |  |  |
| --- | --- | --- | --- |
| Employee Name: |       | Date of Treatment: |       |
| Position: |       | Department: | **FIRE RESCUE** |
| Supervisor Signature: |       | Supervisor Name: |       |

TO BE COMPLETED BY THE TREATING PHYSICIAN AND RETURNED TO THE EMPLOYEE AT THE TIME SERVICE IS PROVIDED.

I have seen and treated the above named patient. His/her diagnosis is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have referred this employee to a specialist. Name of Specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of treatment (physical therapy, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physicians**: The following is a summary of the environmental demands required of Fire Rescue employees/members used to determine work restrictions or full return to duty. Please check those job functions which the employee/member **SHOULD NOT** perform, or indicate the employee can return to full duty. The form must be signed and dated by the attending or designated treating physician.

|  |  |
| --- | --- |
|  [ ]  Lifting and carrying 1 – 100 pounds or no more  than \_\_\_\_\_\_\_ pounds.[ ]  Stooping, crouching, kneeling, twisting and crawling.[ ]  Fingering and handling functions utilizing bilateral fingers and hands.[ ]  Bilateral upper extremity above and below shoulder reaching motions.[ ]  Bilateral upper extremity throwing motion.[ ]  Sitting, standing, waiting.[ ]  Walking, running and jumping activities.[ ]  Climbing utilizing legs and arms.[ ]  Far, near, color, and peripheral vision.[ ]  Hearing, talking, sense of smell and feel. | [ ]  Being outside in fair, wet, hot (>90°F), humid (>70%), dry, cold (<32°F) weather and during  sudden temperature changes.[ ]  Working with moving objects, hazardous  machinery, and sharp tools or materials.[ ]  Working in poor lighting, toxic conditions,  cluttered and slippery floors, wet and close  quarters.[ ]  Working with others, around others and alone.[ ]  Working rotating shifts (hours).[ ]  Exposure to vibration, noise and toxic conditions.[ ]  Wearing a positive pressure breathing apparatus.[ ]  Working in high places.[ ]  Operating/driving motor vehicles  |

Will this employee/member be on any medication that may impair their ability to safely perform the actions/duties listed above or impair their judgment? [ ] YES [ ] NO

[ ]  The employee is released to full duty with no restrictions on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  The employee may work limited duty with the above noted restrictions, until \_\_ \_\_\_\_\_\_

[ ]  The employee is off duty. Approximate return to light/full (circle one) duty is on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN’S NAME (PRINT): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_