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| --- | --- | --- | --- |
| 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.

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| --- | --- |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_