Return to Work Authorization Form

Employee Information and Informed Consent for Disclosure of Health Care Information

Employee MUST return completed form to Fire Administration PRIOR to returning to work.

Employee Name: _____ **ID#:** _____

Division: Ops/Admin/Fire Prevention Position: Firefighter/Peace Officer Normal Work Schedule: 8-24 Hr Shift

Essential Job Functions

- ☑ Walking over unstable surface and terrain
- ☑ Sitting
- ☑ Standing
- ☑ Bending
- ☑ Reaching
- ☑ Kneeling
- ☑ Crawling
- ☑ Hearing
- ☑ Seeing
- ☑ Talking
- ☑ Pushing / Pulling
- ☑ Turning neck and body
- ☑ Finger dexterity / Handling
- ☑ Lifting and carrying up to **70** pounds unassisted
- ☑ Dragging up to **160** pounds unassisted (Firefighters only)
- ☑ Handling & operating high pressure water hoses (Firefighters only)
- ☑ Climbing and standing on ladders
- ☑ Repetitive motion such as typing, data entry, vision to monitor
- ☑ Use of standard office equipment (compute, fax, copy machine)
- ☑ Exposure to extreme temperature and weather conditions
- ☑ Exposure to hazardous chemicals, toxic fumes
- ☑ Exposure to infectious disease, body fluids
- ☑ Driving light/heavy department vehicles
- ☑ Cognitive functions
- ☑ Analytical skills
- ☑ Wearing full protective clothing and self contained breathing apparatus for extended periods of time
- ☑ No work while on controlled substances
- ☐ Additional Information : _____

_____

_____

EMPLOYEE'S HEALTHCARE PROVIDER TO COMPLETE:
(Opinion Based On A Reasonable Degree of Medical Probability)
Check duties that the employee ***cannot*** perform or can only perform in a restricted capacity. Please list restriction next to the task and **indicate when it may be lifted.** (Example ☑Sitting - ***No Sitting for 2 months***; ☑ Lifting - ***10 lbs maximum for 3 months***)

- ☐ Walking _____
- ☐ Sitting _____
- ☐ Standing _____
- ☐ Bending _____
- ☐ Reaching _____
- ☐ Kneeling _____
- ☐ Crawling _____
- ☐ Hearing _____
- ☐ Seeing _____
- ☐ Talking _____
- ☐ Pushing / Pulling _____lbs. maximum _____
- ☐ Turning neck and body _____
- ☐ Finger dexterity / Handling _____
- ☐ Lifting and carrying _____lbs. maximum _____
- ☐ Dragging (unassisted) _____lbs. maximum_____
- ☐ Handling and operating high pressure water hoses _____
- ☐ Climbing and standing on ladders _____
- ☐ Repetitive motion such as typing, data entry, vision to monitor _____
- ☐ Use of standard office equipment (compute, fax, copy machine) _____
- ☐ Exposure to extreme temperature and weather conditions _____
- ☐ Exposure to hazardous chemicals, toxic fumes _____
- ☐ Exposure to infectious disease, body fluids _____
- ☐ Driving light/heavy department vehicles _____
- ☐ Cognitive functions _____
- ☐ Analytical skills _____
- ☐ Wearing full protective clothing and self contained breathing apparatus for extended periods of time _____
- ☐ **Has the employee been prescribed any medication that may affect his/her ability to perform essential function of their job? If Yes—See Pg. 2**
- ☐ Additional Information : _____

_____

*****THE FOLLOWING SECTION IS NOT REQUIRED IF A TEXAS WORKERS COMPENSATION WORK STATUS REPORT WAS COMPLETED*****

HEALTHCARE PROVIDER TO COMPLETE: (choose one)

Based upon a reasonable degree of medical certainty, including your medical knowledge, experiences, and examination of the patient, please provide the following information regarding when the employee will be able to perform the duties of their position (with/without reasonable accommodations), without posing significant risk of harm to himself / herself or others.

1. ☐ **Employee has NO restrictions**
   The above patient/employee has no identified limitations and/or restrictions as of the following date: _____/_____/_____.

2. ☐ **Employee has RESTRICTIONS**
   The patient/employee may return to a limited duty work assignment (example - light office work) so long as he/she adheres to the functional limitations and restrictions identified above as of the following date: _____/_____/_____.
   Expected duration of restrictions: _____.
   ☐ **Reduced Schedule Required**
   Please identify the number of hours per day _____ and/or hours per week _____ that the patient/employee can work.
   Expected duration of a reduced schedule: _____.

3. ☐ **Employee CANNOT return to work**
   The patient/employees' functional limitations and restrictions, identified in detail above, are of such severity that he/she cannot perform activities, even at a sedentary level (e.g. hospitalization, cognitive impairment, infection, contagion), as of the following date: _____/_____/_____.

See Back - All Sections Must Be Completed by Healthcare Provider

Employee Name: _____ **ID#:** _____

The following information must be completed BEFORE the employee will be allowed to return to work

***Prescribed Medications* If the employee was prescribed medication(s) that may affect his or her ability to perform essential functions of their job, please complete the following:**

1) How does the prescribed medication limit and/or restrict the employee's ability to perform essential functions of his or her job?

_____
_____
_____

2) Are there any reasonable accommodations which would allow the employee to perform the essential functions of his or her job limited and/or restricted by the medication(s)?

_____
_____
_____

If the employee is a supervisor (Lieutenant, Captain, Chief) - In your professional opinion, is the employee able to:

1) Exercise sound judgment and rational thinking under stressful and/or dangerous circumstances? ☐Yes ☐No
2) Evaluate various options and alternatives and choose an appropriate and reasonable course of action? ☐Yes ☐No

The need for care was musculoskeletal in nature: ☐Yes ☐No

Additional Comments:

_____
_____
_____
_____
_____

HEALTH CARE PROVIDER INFORMATION

Provider Name (Please Print): _____

Telephone: _____ **Fax:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Signature of Health Care Provider: _____ **Date:** _____

RETURN THIS FORM TO:

Frisco Fire Administration
8601 Gary Burns Drive
Frisco, TX 75034
PHONE: (972) 292-6300
FAX: (972) 292-6319
EMAIL: ReturnToWork@FriscoFire.com

FOR CITY OF FRISCO & FRISCO FIRE ADMINISTRATIVE USE ONLY

☐ **Received FIRE ADMIN (MM/DD/YY)** _____ ☐ **Received COF HR (MM/DD/YY)** _____