Cumru Township Fire Department
Health Restrictions and Reporting Form

Member completes the following:

Member Name: _____ Date of Report: _____

I authorize my Physician to release information about my work restrictions only.

Member Signature: _____

Briefly describe injury, illness or condition being reported: _____

_____

_____

Physician Name: _____ Date of Exam: _____

Physician Signature: _____

I have examined this CTFD member and determined he/she is affected by illness, injury or condition which impairs him/her from safely and effectively performing the tasks checked below:

_____ Operating motor vehicles
_____ Operating motor vehicles over 26,000 GVW
_____ Ascending/descending ladders
_____ utilizing Self-Contained Breathing Apparatus
_____ Lifting/carrying objects > 20 lbs.
_____ Carrying objects > 20 lbs on back
_____ Standing/walking > 10 minutes
_____ Heat/cold exposure >10 minutes

Other restriction(s)/limitation(s): _____

_____

_____

Duration of restriction(s)/limitation(s): _____ Days _____ Requires follow-up examination

For Office Use Only:

Date Received: _____ Received By: _____

Duty Restriction(s) Imposed: _____

Duration of Duty Restriction(s): _____ Days _____ until cleared by physician

Officer signature: _____

References:
Policy 10.8 Health Restrictions and Reporting