

Broome County Office of Risk & Insurance Management

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Treating Physician's Volunteer Firefighter Report

To the volunteer firefighter: You must give this form to your physician at each visit

FIREFIGHTER NAME _____
FIRE DEPARTMENT _____
DATE OF INJURY _____

For Physician use only

- In your medical opinion is this injury related to the individual's job? Yes No
- Current loss of earning capacity (Please Circle) 0% to 25% 25% to 50% 50% to 75% 75% to 100%
- Taking into consideration the degree of disability you identified the employee:
 Can return to regular employment without restrictions Cannot return to work until _____ / _____ / _____
 Return to employment with restrictions indicated below effective _____ / _____ / _____ through _____ / _____ / _____

Please explain in detail in the "Additional Comments" the nature of your patient's limitation in terms of Hours / Weight. / Range of Motion, etc.

ADDITIONAL COMMENTS

- | | | | | |
|-----------------------------|----------------------------------|---------------------------------------|-------------------------|-----------------|
| <input type="checkbox"/> No | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | PUSHING | _____ |
| <input type="checkbox"/> No | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | PULLING | _____ |
| <input type="checkbox"/> No | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | BENDING | _____ |
| <input type="checkbox"/> No | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | STOOPING | _____ |
| <input type="checkbox"/> No | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | SITTING | _____ |
| <input type="checkbox"/> No | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | STANDING | _____ |
| <input type="checkbox"/> No | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | TWISTING | _____ |
| <input type="checkbox"/> No | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | CLIMBING | _____ |
| <input type="checkbox"/> No | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | KNEELING | _____ |
| <input type="checkbox"/> No | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | LIFTING | _____ Lbs. Max. |
| <input type="checkbox"/> No | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | OVERHEAD LIFTING | _____ Lbs. Max. |

Additional restrictions: _____

Authorization for the following treatment/test is hereby requested: _____

Date of this Exam: _____ Date of Next Appointment: _____

Physician Signature : _____

Physician's Name, Address and Phone #: _____

Please Print