Roosevelt Fire District
POST OFFICE BOX No. 394
HYDE PARK, NEW YORK
(845) 229-8850
OFFICE OF THE CHIEF

MEDICAL RESTRICTION/RETURN TO DUTY FORM

NAME: _____ RFD ID # _____

MEMBER SIGNATURE: _____

DIAGNOSIS: _____

DATE OF ONSET: _____/_____/_____ RESTRICTIONS UNTIL: _____/_____/_____
(MAXIMUM ONE (1) year from onset of Symptoms/Injury)

The individual named above is a patient currently under my care. I have advised them of the following temporary restrictions/limitation(s) in their ability to function as a member of the Roosevelt Fire District.

MEDICAL PROVIDER PLEASE CHECK ALL THAT APPLY:

- ☐ This illness/injury is connected to a Workman's Compensation or VFBL Case (**NO ACTIVITY ALLOWED** – as per district policy)
- ☐ RETURN TO FULL DUTY – **NO RESTRICTIONS**
- ☐ NO PHYSICAL ACTIVITY ALLOWED
- ☐ CAN ATTEND MEETINGS, CLASSROOM TRAINING (Not involving physical activity), PERFORM CLERICAL DUTIES, ATTEND SOCIAL EVENTS
- ☐ LIFTING RESTRICTIONS of _____ pounds

MEDICAL PROVIDER NAME: _____ VISIT DATE: _____/_____/_____

PROVIDER SIGNATURE: _____

DATE OF FOLLOW UP (If needed): _____/_____/_____

OFFICE STAMP:

OFFICE ADDRESS:

_____
_____
_____

PLEASE FAX COMPLETED FORM TO FIRE DISTRICT SECRETARY at (845) 454-4580