



NORTHAMPTON COUNTY

Department of EMERGENCY MEDICAL SERVICES



STANDARD OPERATING GUIDELINES

TOPIC: Fitness for Duty ~ Medical Provider Statement	SOG #: 2.03.2
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Status: ACTIVE	Written: 04/08/2004
Written by: Hollye B. Carpenter	Revised: 02/12/2013
Approved by: Hollye B. Carpenter	Adopted: 06/05/2013

PURPOSE

The Northampton County Department of Emergency Medical Services requires a fitness for duty statement from a medical provider if out of work for thirty-six (36) hours or more.

SCOPE

All Emergency Medical Services Providers

CONTENT

EMS Provider's Name:

Reported Health Condition:

I consent to the release of medical information requested with regard to the health condition referenced above.

Signature:	Date:
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TO BE COMPLETED BY ATTENDING PHYSICIAN:

1. Date of Illness/Injury/Surgery: _____
2. Date of Last Office Visit: _____
3. Does health condition require frequent periods away from work? If yes, please explain: _____
4. Is this individual taking medications that would cause drowsiness or other impaired mental status or physical symptoms while at work? If yes, please list: _____

5. PLEASE CHECK APPLICABLE WORK STATUS:

- Unable to work from _____ through _____
Date Date
- May return to work:
 - Full Duty effective: _____
 - Limited Duty effective: _____



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6. PLEASE CHECK ANY OF THE FOLLOWING RESTRICTIONS OR LIMITATIONS WHICH MAY APPLY:

- No restrictions or limitations.
- Currently taking medications which may hinder job performance or alter independent judgment and discretion in the execution of the assigned duties of an EMS provider.
- Unsatisfactory emotional functions or mental ability of clear and sound mind exist which may hinder ability to create patient care plans.
- May not operate motor vehicle.
- May operate motor vehicle for a distance/time of _____.
- No repetitive bending or stooping.
- No sitting longer than _____.
- No walking or standing longer than _____.
- No lifting or carrying of objects exceeding _____ pounds.
- May not exert, push, or pull force exceeding _____ pounds.
- No participation in strenuous physical activities.
- No overhead work.
- Insufficient gross or fine motor coordination to manipulate EMS equipment and accessories.
- Insufficient eyesight to observe patients and manipulate equipment/accessories.
- Insufficient hearing to communicate with patients and other members for the healthcare team.
- No work longer than _____ hours per day or within a 24 hour period.

7. Expected duration of restriction(s): _____.

Name of EMS Provider: _____

Name of Physician: _____

Address of Physician: _____

Phone Number of Physician: _____

Signature of Physician: _____

Date: _____