Santa Cruz County Fire Department
MEDICAL TREATMENT/RETURN TO WORK

Reset Form Print Form

MEDICAL TREATMENT/RETURN TO WORK

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

TO: SUPERVISOR, INJURED WORKER, AND ATTENDING DOCTOR
Provide this form and attachments to the doctor. The signed original is to be returned and maintained by the Return-to-Work Coordinator (Industrial) or Administrative Unit (Non-Industrial). If the injury is work-related, attach this form to the Employee's Claim for Workers' Compensation Benefits (DWC-1) and the Employer's Report of Occupational Injury or Illness. Attach the volunteer's Physical/Mental Stress Job Description to this form. This form is to be completed and sent to the Supervisor and/or Return-To-Work Coordinator upon **EACH** visit that the injured volunteer has with the doctor/medical provider.

NAME OF INJURED/ILL VOLUNTEER	CLASSIFICATION	DATE OF INJURY
NAME OF EMPLOYER/INSTITUTION Santa Cruz County Fire Department		PHONE # 831-335-6734
ADDRESS CITY, STATE ZIP CODE PO Drawer F-2 Felton, CA 95018		
SUPERVISOR'S NAME	SUPERVISOR'S CLASSIFICATION	PHONE

INJURY STATUS REPORT

TO: ATTENDING DOCTOR/MEDICAL PROVIDER **DATE OF TREATMENT:** _____

Check the boxes below that apply. A short-term, modified work assignment may be available. Direct any questions on modified work assignments to the employee's supervisor. Return this form to the employee or the authorized person that accompanied him or her.

This confirms the above individual received medical treatment for an injury or illness that is: (check one)

☐ Non-work-related ☐ Work-related ☐ May be work-related ☐ Unknown

I have considered the following in determining the injured worker's ability to perform his or her work duties as stated within the injured worker's: ☐ County Fire Physical/Mental Stress Job Description ☐

TREATMENT ADMINISTERED	WORK STATUS	PHYSICAL/MENTAL LIMITATIONS
☐ Office visit/initial injury treatment ☐ Re-evaluation ☐ Redress ☐ Medication ☐ Physical therapy ☐ Physical exam ☐ Referred/follow-up treatment/exam on: _____ by: _____ ☐ Telephone advice: _____ ☐ Other: _____ ☐ Assistive devices: _____ ☐ Explanatory information attached	☐ Return without restrictions on: _____ ☐ Return to Modified work on: _____ (Attach detailed modifications.) ☐ Unable to work until: _____ ☐ Never able to return to assigned work from: _____ (Attach explanation) ☐ Medication effects on performance: _____ _____	☐ No prolonged or ☐ No: ☐ Standing ☐ Walking ☐ Climbing ☐ Bending ☐ Sitting ☐ Stooping ☐ Limited use of hands: ☐ Left ☐ Right ☐ Work near machinery: ☐ No ☐ Modified ☐ Twisting motion: ☐ No ☐ Modified ☐ Weight lifting restriction/duration: Restriction: _____ pounds Duration: ☐ 1-33%--Occasional ☐ 34-66%--Frequent ☐ 67-100%--Constant Date(s) limitations apply: From: _____ To: _____

As of this date, the undersigned certifies that the information contained in this document is true and accurate to the best of his/her knowledge and is in compliance with Labor Code Section 139.3.

DOCTOR/MEDICAL PROVIDER		PHONE ( )	FAX ( )
ADDRESS	CITY	STATE	ZIP CODE
SIGNATURE		DATE	

TO BE COMPLETED BY VOLUNTEER

VOLUNTEER COMMENTS: NEXT APPOINTMENT DATE: _____

VOLUNTEER SIGNATURE: _____ DATE SIGNED: _____