

**HEALTHCARE PROVIDER'S CERTIFICATE  
SERIOUS HEALTHCARE CONDITION FOR SELF  
LEAVE FOR MORE THAN 3 WORK SHIFTS**

Submit completed form to:  
Fire Department HR Representative  
645 Randolph Avenue  
Saint Paul, MN 55102  
Fax# (651) 228-6255

**NOTE TO EMPLOYEE:**

**This form is to be completed by your treating Healthcare Provider. You must promptly provide a copy of this report or equivalent information to Fire Department Human Resource Representative. In order to return back to Fire/EMS Division (Fire Sworn), the return to work certificate is required to be completed.**

EMPLOYEE NAME: \_\_\_\_\_ Emp. ID #: \_\_\_\_\_  
(Type or Print)

TITLE: \_\_\_\_\_ Are you a licensed Firefighter/EMT? ☐Yes ☐No Are you a paramedic? ☐Yes ☐No

I hereby grant permission to \_\_\_\_\_ to supply the information requested regarding my workability.

EMPLOYEE'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**HEALTHCARE PROVIDER SECTION**

**The purpose of this certificate is to verify the workability of the above-named employee to include the necessity to be absent from work, the ability to work with restrictions, or ability to return back to work.**

1. Was the illness/injury work related? ☐Yes ☐No ☐Undetermined

2. Date of Most Recent Medical Appointment: \_\_\_\_/\_\_\_\_/\_\_\_\_

3. Employee is unable to perform any duties from: \_\_\_\_/\_\_\_\_/\_\_\_\_ to: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Note: Further medical documentation may be required under the City's FMLA Policy and Accommodation Policy)

4. Return to work if the following limitations can be met on: from \_\_\_\_/\_\_\_\_/\_\_\_\_ through: \_\_\_\_/\_\_\_\_/\_\_\_\_

☐No lift/carry over \_\_\_\_ pounds ☐No push/pull over \_\_\_\_ pounds ☐No use of R / L arm above shoulder

☐No Use of R / L Arm/Hand ☐No repetitive use of R / L Arm/Hand ☐No use of arm away from body

☐No power grip/pinch ☐Must wear gloves ☐Wear splint

☐No sustained bend/twist at waist ☐No repetitive bend/twist at waist ☐Change posture as needed

☐Must keep R / L leg elevated ☐Walk only with crutches ☐Minimal walking

☐No stair/ladder climbing ☐No prolonged standing ☐Seated work only

☐No squatting ☐No driving of: \_\_\_\_\_ ☐Keep wound dry and clean

☐Limited work hours \_\_\_\_ per day \_\_\_\_ per week ☐No 24-hour shifts

5. Follow-up medical appointment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_

6. Return to work without limitations on: \_\_\_\_/\_\_\_\_/\_\_\_\_

**RETURN TO WORK CERTIFICATION – FIRE/EMS Division**

**If the employee is able to return back to work in Fire/EMS Division, the employee's healthcare provider or the department's occupational health provider (upon request) is required to complete the return to work certification on the back page. An employee is unable to return back to work until completed to satisfaction. →→→→→→→→→→→→**

Healthcare Provider's Name/Title: \_\_\_\_\_  
(Please Print)

Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## RETURN TO WORK CERTIFICATION

Please consider the physical, physiological, intellectual and psychological demands of a licensed Firefighter/EMT/ Paramedic when completing this certification and your knowledge of the employee's injury / illness. Job descriptions and physical requirements are available upon request. Please confirm the licensed firefighter is able to safely perform the following tasks:

### Fire Suppression & Emergency Services Positions (ALL Sworn Personnel):

- Extensive crawling, lifting and carrying heavy objects, ventilating roofs or walls using power or hand tools, forcible entry? ☐Yes ☐No
- Use a respirator including a SCBA with the ability to tolerate increased respiratory workloads in an IDLH (lethal) environment? ☐Yes ☐No
- The employee can tolerate being exposed to toxic fumes, irritants, particulates, biological and non-biological hazards, and/or heated gasses, despite the use of personal protective ensembles and a SCBA? ☐Yes ☐No
- Climb flights of stairs, including high-rise buildings, while wearing PPE weighing at least 50 pounds or more and carrying equipment/tools weighing an additional 20 to 40 pounds? ☐Yes ☐No
- Conduct searching, finding and rescue-dragging or carrying victims up to adults weighing over 175 pounds to safety despite hazardous conditions and low visibility? ☐Yes ☐No
- Climb ladders, operate from heights, walk or crawl in the dark along narrow and uneven surfaces? ☐Yes ☐No
- Ability to communicate (give and comprehend verbal orders), while wearing PPE and SCBA under conditions of high background noise, poor visibility, and drenching from hose-lines and/or fixed protection systems (sprinklers)? ☐Yes ☐No
- Ability to perform CPR for 2-5 minute cycles? ☐Yes ☐No
- Ability to function as an integral component of a team, where sudden incapacitation of a member can result in mission failure or in risk of injury or death to civilians or other team members? ☐Yes ☐No
- Ability for critical, time-sensitive complex problem solving during physical exertion in stressful, hazardous environments, including hot, dark, tightly enclosed spaces that are further aggravated by fatigue, flashing lights, sirens and other distractions? ☐Yes ☐No
- Operate/Drive a fire apparatus, other vehicles and equipment in an emergency mode at above posted speeds with emergency lights and sirens? ☐Yes ☐No

### Paramedics:

- Employee working as a Paramedic has the dexterity and fine motor skills needed for small precise controls such as starting an IV or intubation while possibly performing these tasks in small areas? ☐Yes ☐No

1. Based upon your medical review, is the employee a medical threat to self or others due to the illness/injury that caused the employees absence? ☐Yes ☐No ☐Undetermined
2. Is the employee on any medications that may impact the employee's ability to safely perform their position including but not limited to emergency driving, working with machinery, and ability to perform work upon being woken from sleep? ☐Yes ☐No
3. Are you requesting an Occupational Health Exam to certify return to work? ☐Yes ☐No
4. Are you requesting a respiratory exam by Occupational Health Exam as part of the certification to return to work? ☐Yes ☐No
5. Return to work without limitations on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Provider's Name (Print): \_\_\_\_\_

Provider's Signature \_\_\_\_\_

Clinic Name & Address: \_\_\_\_\_

Phone: \_\_\_\_\_

NOTE: Submit completed form to Fire Department HR Representative Nancy Denkinger