

THE GAINESVILLE POLICE DEPARTMENT'S FITNESS FOR RETURN TO DUTY CERTIFICATION FORM (Sworn Personnel)

Name: _____ ID# _____ Date: _____

This form shall be completed by a physician if an employee sustains an injury or, has a contagious and/or debilitating illness which substantially* affects his/her ability to perform the essential functions of his/her job class. The City Occupational Health Nurse may complete the forms for all other incidents of illness and/or injury. **To complete this form, the complete essential functions block must be completed along with the "Status Information" section.** Additionally, the Personnel Division Commander or designee may request completion of the forms if he or she has reason to believe that the health and safety of the Department, its employees and/or the citizens of the City of Gainesville may be at risk. If you need assistance completing this form, contact the Personnel Services Division at the Gainesville Police Department at 393-7595.

*(Injuries or illnesses that limit the employee's ability to perform the essential functions of the job.)

Essential Physical Functions for Sworn Personnel: (Physical/City Occupational Health Nurse please check appropriate boxes)

As treating physician/nurse, I have examined the employee. This employee has the following limitations:

- | | |
|--|--|
| <input type="checkbox"/> Unable to participate in physical force situations or training
<input type="checkbox"/> Unable to stand for extended periods of time, up to 4 hours during an 8 or 10 hour shift
<input type="checkbox"/> Unable to run or jump
<input type="checkbox"/> Unable to lift objects of at least 20 lbs
<input type="checkbox"/> Unable to perceive movement and depth of field
<input type="checkbox"/> Unable to detect odors
<input type="checkbox"/> Unable to discriminate sounds
<input type="checkbox"/> Unable to determine direction sounds originate
<input type="checkbox"/> Unable to discriminate different colors
<input type="checkbox"/> Unable to negotiate a 4 foot high fence and other similar obstacles
<input type="checkbox"/> Unable to keep hand and arm steady
<input type="checkbox"/> NO RESTRICTIONS | <input type="checkbox"/> Unable to make skillful, coordinated movement two hands (manual dexterity)
<input type="checkbox"/> Unable to make skillful, coordinated movement of fingers of one or two hands (finger dexterity)
<input type="checkbox"/> Unable to sit in a motor vehicle for extended periods of time up to 6 hours during an 8 or 10 hour shift
<input type="checkbox"/> Unable to work all shifts: work rotating shift
<input type="checkbox"/> Unable to push a small car on a flat surface
<input type="checkbox"/> Unable to climb stairs
<input type="checkbox"/> Unable to climb through windows
<input type="checkbox"/> Unable to evacuate an unconscious person from a danger area
<input type="checkbox"/> Unable to meet visual acuity requirements for issuance of a Florida "Operator" Driver's License
<input type="checkbox"/> Unable to work effectively under stressful conditions
<input type="checkbox"/> Other: _____ |
|--|--|

Expected duration of limitations _____

Status information: (Completed by Physician and/or City Occupational Health Nurse)

This employee has been evaluated and it is recommended that he/she be placed into the following status:

- | | |
|--|---|
| <input type="checkbox"/> Restricted
Unable to perform all the above essential functions of the job class | <input type="checkbox"/> Unrestricted
Able to perform a the job class the job class |
|--|---|

This employee has been evaluated and he/she is eligible for the following type of assignment:

- | | | |
|---|--|---|
| <input type="checkbox"/> Restricted Duty assignment
Work assignments based on above limitations | <input type="checkbox"/> No work assignment
Condition would not tolerate any work assignment | <input type="checkbox"/> Regular Duty assignment
Able to work or return to normal duty assignment |
|---|--|---|

Print Physician's Name: _____ Physician's Signature: _____ Date: _____

City Occupational Health Nurse's Signature: _____ Date: _____

Personnel Command/designee: _____	Rehabilitative Duty	<input type="checkbox"/> Approved <input type="checkbox"/> Denied	Date: _____
Chief of Police/designee: _____	Rehabilitative Duty	<input type="checkbox"/> Approved <input type="checkbox"/> Denied	Date: _____