SHERMAN VOLUNTEER FIRE DEPARTMENT

FITNESS FOR DUTY EVALUATION

PATIENT NAME: _____

PHYSICIAN NAME: _____

ADDRESS:_____
_____

TELEPHONE:_____

EXAMINATION DATE:_____

Based on the physical examination performed and on file in my office, the above named member is:

_____ medically certified for firefighter/EMS responsibilities

_____ medically certified with the following restrictions:

____ NOT Medically certified for firefighting/EMS duties

RESPITORY FITNESS DETERMINATION

OSHA RESPITORY MEDICAL EVALUATION QUESTIONAIRE COMPLETED YES / NO
(REQUIRED TO COMPLETE RESPITORY FITNESS)

_____ **Category 1 – Certified NO impairment that would limit respiratory use.**

_____ Category 2 – NOT certified. Impairment present that preclude safe respiratory use

_____ Category 3 - Certified for respiratory use with the following restrictions:

TESTS:

PPD YES NO DATE:_____

HEP B YES NO DATE:_____

PHYSICIAN'S SIGNATURE: _____

DATE: _____