



Firefighter Medical Follow-Up Form
Hypertension

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Dear Doctor: The employee named above was seen by our staff for a Firefighting Clearance Examination. In order for a Firefighter to obtain or maintain certification when a medical condition is present, the patient must obtain medical follow-up from his/her personal physician documenting that the condition is diagnosed, treated, and under control.

The employee has been informed of the rationale for this follow up request. By signing below, he/she gives approval to WorkFit Medical, LLC to share documentation concerning this case with his/her personal physician.

We thank you in advance for completing this form and faxing it back to WorkFit Medical, LLC at one of the fax numbers listed below.

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

Comments/Conditions: Hypertension
Physical Examination shows elevated Blood Pressure: \_\_\_/\_\_\_, \_\_\_/\_\_\_, \_\_\_/\_\_\_
Patient carried the diagnosis of HTN. Please comment on stability and include most current lab results.
Requested by: \_\_\_\_\_

Please Complete and Verify:

- 1. The above named patient is under my medical supervision for the above condition and has been seen at my office within the last 6 months.
2. Has the patient been diagnosed with HTN?
3. Has the condition been addressed or treated and stabilized?
4. Current Treatment (if medications, please attach list)
5. Is patient compliant with treatment?
6. In your opinion, can the above stated patient safely work without restrictions?
7. Does this patient have any other condition which would interfere with his/her ability to work?

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_
Doctor's Printed Name: \_\_\_\_\_ Office Phone: \_\_\_\_\_
Office Street Address: \_\_\_\_\_ Office Fax: \_\_\_\_\_
City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

(WorkFit use only)
Date Reviewed: \_\_\_\_\_
Provider Signature: \_\_\_\_\_
Employee meets follow-up requirements for \_\_\_ months.
Employee does not meet follow-up requirements.
Other: \_\_\_\_\_

\*\*\*Must Be Filled out and Returned by \_\_\_\_\_\*\*\*

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