WorkFitMedical
Occupational Health Services

Firefighter Medical Follow-Up Form
Cardiovascular

Patient's Name: _____ DOB: _____

Dear Doctor: The employee named above was seen by our staff for a Firefighting Clearance Examination. 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: **Cardiovascular**

☐ Evaluation reveals abnormal EKG: _____

☐No previous EKG for comparison ☐ Shows changes from previous EKG on file

☐ Patient carries the diagnosis of Cardiovascular disease. Please comment on stability.

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. ☐ Yes ☐ No Date of last visit: _____
2. Has the patient been diagnosed with cardiovascular disease? ☐ Yes ☐ No
   Diagnosis: _____
3. Has the condition been addressed or treated and stabilized? ☐ Yes ☐ No
   (If no, please comment on stability of the condition) _____
4. Current Treatment (if medications, please attach list) _____
5. Most recent Stress Test date: _____ Results:_____
   6. Is patient compliant with treatment? ☐ Yes ☐ No
7. In your opinion, can the above stated patient safely work as a firefighter without restrictions? ☐ Yes ☐ No
   Comments:_____ _____
8. Does this patient have any other condition which would interfere with his/her ability to work as a firefighter? ☐ Yes ☐ No
   (if yes, what?) _____

Doctor's Signature: _____ Date: _____
Doctor's Printed Name: _____ Office Phone: _____
Office Address: _____ Office Fax: _____
City: _____State: _____ Zip: _____

***Must be filled out and returned by _____ ***

(WorkFit use only)
Date Reviewed: _____
Provider Signature: _____

☐ Employee meets follow-up requirements for ____ months.
☐ Employee does not meet follow-up requirements.
☐ Other: _____

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