



Hazmat Medical Follow-Up Form
Hypertension

Patient's Name: _____ DOB: _____

Dear Doctor: The employee named above was seen by our staff for a Hazmat Clearance Examination. For a Hazmat member 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: ____/____, ____/____, and ____/____
☐ 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. Yes ____ No ____ Date of last visit: _____
2. Has the patient been diagnosed with HTN? Yes ____ No ____ **Blood Pressure at last visit** ____/____
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. Is patient compliant with treatment? Yes ____ No ____
6. In your opinion, can the above stated patient safely participate in hazardous waste operations and response with this condition and/or while on the medication listed above? Yes ____ No ____
(If no, why not?) _____
7. Does this patient have any other condition(s) which would interfere with his/her ability to safely perform Hazmat duties? Yes ____ No ____ (If yes, what?) _____

Doctor's Signature: _____ Date: _____

Doctor's Printed Name: _____ Office Phone: _____

Office 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: _____