HOUSTON FIRE DEPARTMENT

VERFICATION OF HEALTH CARE PROVIDER VISIT FOR NON-OCCUPATIONAL INJURY / ILLNESS

SECTION 1: SHALL BE COMPLETED BY THE EMPLOYEE

NAME: _____ (LAST) _____ (FIRST) _____ (MI)

PAYROLL: _____ RANK OR TITLE: _____ DIVISION: _____

DISTRICT: _____ STATION: _____ SHIFT: _____ DEBIT DAY: _____

☐ EMPLOYEE INJURY OR ILLNESS — EMPLOYEE PHONE CONTACT: _____

☐ SICK FAMILY MEMBER — RELATIONSHIP TO EMPLOYEE: _____

☐ WELLNESS OFFICE VISIT

_____ (DATES OF ABSENCES)

SECTION 2: SHALL BE COMPLETED BY THE HEALTH CARE PROVIDER

NAME OF HEALTH CARE PROVIDER _____

HEALTH CARE PROVIDER ADDRESS _____

HEALTH CARE PROVIDER PHONE NUMBER _____

DATE OF OFFICE VISIT _____

DATE OF PROVIDER SIGNATURE _____

HEALTH CARE PROVIDER SIGNATURE _____

SECTION 3: SHALL BE COMPLETED BY THE HEALTH CARE PROVIDER

DATE EMPLOYEE RELEASED TO **FULL DUTY** WITHOUT RESTRICTIONS _____

OR

DATE EMPLOYEE RELEASED TO **LIMITED DUTY** WITH RESTRICTIONS _____

EMPLOYEE IS **RESTRICTED** FROM THE FOLLOWING ACTIVITIES (CHECK ALL APPLICABLE BOXES)

☐ BENDING ☐ CRAWLING ☐ KNEELING ☐ REACHING ☐ STANDING

☐ CLIMBING ☐ DRIVING ☐ LIFTING ☐ PIVOTING ☐ STOOPING

☐ OPERATE OR WORK NEAR EQUIPMENT _____

☐ ADDITIONAL WORK RESTRICTIONS _____

SECTION 4: SHALL BE COMPLETED BY THE RECEIVING SUPERVISOR

DATE HFD FORM 48 RECEIVED: _____ TIME RECEIVED: _____

SUPERVISOR NAME (PRINT): _____ PAYROLL: _____

SUPERVISOR SIGNATURE: _____ RANK OR TITLE: _____

SECTION 5: TO BE CONSIDERED VALID THE HFD FORM 48 MUST:

HAVE SECTIONS 1 AND 2 COMPLETED (FOR EMPLOYEE FAMILY MEMBER'S CONDITION);
HAVE SECTIONS 1, 2 AND 3 COMPLETED (FOR EMPLOYEE OWN CONDITION);
HAVE SECTION 4 COMPLETED BY SUPERVISOR**;** COVER ALL DATES OF ABSENCES;
BE SIGNED BY A HEALTH CARE PROVIDER AS DEFINED IN APPENDIX A;
BE SUBMITTED WITHIN **TEN (10) CALENDAR DAYS** (EXCLUDING THE INITIAL DATE OF REQUESTED LEAVE) AND EVERY **THIRTY (30) CALENDAR DAYS** THEREAFTER FOR THE DURATION OF THE BONA FIDE NON-OCCUPATIONAL ILLNESS, DISEASE, OR INJURY.