

**ORLANDO POLICE DEPARTMENT POLICY AND PROCEDURE**  
**1619.6 ALTERNATIVE DUTY ASSIGNMENTS/NO DUTY STATUS**

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**POLICY:**

Members of the Orlando Police Department with temporarily diminished physical capabilities as a result of illness, injury, pregnancy, etc., may, at the discretion of the Chief of Police, be assigned to alternative duty. The primary priority for such assignments shall be the augmentation of line services. Nonsworn employees (civilians) should refer to the appropriate City of Orlando policy and procedures.

This policy establishes guidelines and responsibility regarding alternative duty assignments pursuant to line-of-duty and non-line-of-duty injury or illness, but not related to any injury or illness pursuant to the current issue of P&P 1117, Extra-Duty and Outside Employment.

No-Duty Status: A member will be in a No-Duty Status when either the City's occupational healthcare provider or private physician has determined that he/she is not physically capable of performing normal police duties, or does not qualify for alternative duty assignment. These members shall be required to remain in an authorized leave status (i.e., sick leave, personal leave, compensatory time, family leave), until they can return to full duty or become eligible to work an alternative duty assignment.

**PROCEDURES:**

**1. REQUIREMENTS FOR ALTERNATIVE DUTY**

**1.1 ON-DUTY INJURIES**

Once the member has been released to Alternative Duty by the City's occupational healthcare provider, the member must return to work immediately or apply for Family and Medical Leave (FMLA), as outlined in Policy and Procedure 1607. Members who elect to apply for FMLA will not be able to request reimbursement of sick leave or personal leave if such use is related to an injury/illness that occurred in the line of duty. There are no minimum requirements for alternative duty assignment after an on-duty injury. (See Attachment A for On-Duty Injuries checklist.)

The provider status report (from the physician) shall be attached to the request memo and all updates regarding the on duty injury. This is called the Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form (This can be found on the last page).

## 1.2 OFF-DUTY INJURIES

In order to qualify for alternative duty assignments, members must be certified by a licensed physician to have capabilities diminished on a temporary basis to the extent the member can no longer perform tasks required in the full application of police powers. Additionally, members must be capable of performing all of the following requirements: (See Attachment B for Off-Duty Injuries checklist.)

- a. Respond to non-hazardous calls for service.
- b. Write police reports.
- c. Interview victims and witnesses.
- d. Work shift work.
- e. Work 40 hours per week.
- f. Be able to ride in a police vehicle and be able to enter and exit the vehicle unassisted.
- g. Operate a police radio.

## 2. NO-DUTY STATUS

If a member is unable to meet these minimum alternative duty requirements and is placed on a no-duty status by either the City's occupational health provider or a private physician, then he/she shall immediately, or as soon as circumstances allow, notify the Patrol Services Bureau aide, via email, of his/her no-duty status. The member shall also immediately, or as soon as circumstances allow, submit a memo, with the physician's status report attached, to the Chief of Police, via the chain of command. The memo must include a description of the injury, the estimated length of no-duty status, and the projected date of return to an alternative duty status or to full duty.

## 3. APPLICATION FOR ALTERNATIVE DUTY

### 3.1 ON-DUTY INJURIES

A qualified member injured in the line of duty must request alternative duty immediately following the City's occupational healthcare provider evaluation by submitting a memo to the Chief of Police, via the chain of command, with the City's occupational healthcare provider status report attached. The memo should include a brief description of how the injury occurred, estimated length of alternative duty, list of limitations and restrictions, any medication that might impair the member, prognosis for recovery, and the projected date of Maximum Medical Improvement (MMI). The memo shall not include a request for a specific assignment.

The division commander, upon receipt of the memo and the City's occupational healthcare provider status report for a-line-of-duty injury or illness, shall immediately assign the member to temporary alternative duty for in-the-line-of-duty injury cases. The memo and the City's occupational healthcare provider status report, with the chain-of-command endorsements, must be completed prior to reaching the Chief of Police, who will be the final authority in deciding to approve a request for alternative duty and assignment.

### 3.2 OFF-DUTY INJURIES

Members who request an alternative duty assignment resulting from illness, injuries, etc., not occurring in the line of duty will be required to have their private physician complete and sign a Request for Alternative Duty memo (Attachment C). The member must also complete a memo to the Chief of Police, via the chain of command. The memo should include a brief description of the injury or illness, estimated length of alternative duty, list of limitations and restrictions, any medication that might impair the member, the prognosis for recovery, and the projected date of MMI. The memo may not request a specific assignment. The completed form and memo must be submitted to the Chief of Police for approval via the chain of command. Members must remain in an authorized leave status until the request is approved. Do not report to the City's occupational healthcare provider for non-line-of-duty illness or injuries.

Alternative duty assignments will not be authorized for members who reach MMI and are unable to return to full and unrestricted duty, unless they have a pending pension application and have been so authorized by the Chief of Police. Once MMI has been reached and the member cannot return to full and unrestricted duty, the member must retire, resign, or seek an alternative position within the City within time limits established in Section 4.

#### 4. ADMINISTRATION

The Chief of Police and bureau commanders will determine the nature and type of any alternative duty assignments.

Members may continue their primary assignment if the efficiency of the unit will not be affected. (Example - A member normally assigned to administrative duties could continue that assignment after knee surgery.)

Members given alternative duty assignments will be responsible for forwarding all City occupational healthcare provider status report updates through their permanent chain of command and to the Patrol Services Bureau Aide, who will maintain a file of all alternative duty assignments. Bureau commanders will be responsible for monitoring employees from their bureaus who are on alternative duty, regardless of the employee's alternative duty assignment.

Bureau commanders will give written notice to members who are on alternative duty, sick leave, personal leave due to illness or injury, or leave of absence/family leave for six continuous months and again at nine continuous months. This notice will advise the member to comply with Section 4 of this directive. The member's failure to resign, retire, or obtain an alternative position within the City within the time limits established in Section 4 will result in termination.

Alternative duty assignments will include, but are not limited to, Community Service Officer first responder duties and other nonhazardous police duties.

For a member who is in an authorized alternative duty status, supervisors shall ensure that the informational pay code "Info Alternative Duty" is added, with comments, on his/her Kronos for each date of the alternative duty.

#### 5. DURATION

Members who are on alternative duty resulting from an in-the-line-of-duty injury shall report to the City's occupational healthcare provider every 30 days for evaluation. Members who are on alternative duty resulting from a non-line-of-duty injury shall be evaluated every 30 days by their private physician, who shall complete the Request for Alternative Duty memo. Every time a member receives an update on the injury, they must immediately give all paperwork to their supervisor, who will forward it through the chain of command. Failure to provide any 30-day evaluation report shall subject the member to discipline and may result in revocation of alternative duty assignment.

All members on alternative duty shall contact the Employee Health and Safety Manager at 407.246.3676 if they fall under one of the following categories:

- a. Members who have reached MMI and continue to be unable to return to full duty due to their line-of-duty or non-line-of-duty injury or disability.
- b. Members who have not reached MMI within 11 months from the date of their injury.

The Employee Health and Safety Manager will assist the member in complying with City Policy and Procedure 101.4, Americans with Disabilities Act.

Any member in any combination of the below-listed categories for one continuous year or 12 cumulative months out of any 18-month period will be required to return to full duty:

- a. Alternative duty.
- b. Sick leave or personal leave used as a result of illness or injury.

- c. Leave of absence due to disability, illness, or injury.
- d. Family leave due to disability, illness, or injury of the employee.

Those members unable to return to full and unrestricted duty will be terminated from employment. Such an employment termination will have no bearing upon decisions concerning the member's eligibility for pension. Members are cautioned to file any pension requests prior to termination. In the event employment is terminated, the member may be eligible for reinstatement during the next 24 months in accordance with Civil Service procedure and City policy, provided the member is able to return in an unrestricted or limited alternative duty status.

## **6. CONDITIONS WHILE ON ALTERNATIVE DUTY**

Conditions while on alternative duty are as follows:

- a. Members are prohibited from working extra-duty jobs that entail the wearing of the police uniform or need for police authority.
- b. Members shall not present themselves as an officer to the general public (i.e., wearing their badge and firearm in open view).
- c. Members may work jobs not related to law enforcement, as long as the employment does not interfere with the condition(s) resulting from the alternative duty status. All employees shall comply with the City's Ethics Manual and City Policy 800.5, Prevention of Conflict of Interest. Employees must have a Request for Authorization for Outside Employment on file in City Personnel.
- d. Members will not utilize arrest powers or engage in police related activity requiring the use of force, except in the defense of life.
- e. Members are prohibited from taking a Department issued firearm out of state.
- f. Members may be allowed to participate in in-service training or attend special schools upon approval of the Bureau Commander.
- g. If a promotional examination in which the member would normally be eligible to participate is given while the member is on alternative duty, the member will be allowed to participate in the promotional process.
- h. Effective August 1, 2015, members placed on alternative duty on or after this date are prohibited from participating in the take-home vehicle program.

An Alternative Duty Assignment Notice (Attachment D), available in PowerDMS, will be served on members assigned to this status.

## **7. REQUIREMENTS TO REMAIN IN AUTHORIZED LEAVE STATUS**

Members who are not authorized alternative duty assignments and who are physically unable to perform normal duties shall be required to continuously remain in an authorized leave status (i.e., sick leave, personal leave, compensatory time, family leave).

In addition, eligible members of the Sick Leave Bank who have suffered a non-duty-related injury, illness, or disability may remain in an authorized leave status if all the requirements are met for eligibility in the Sick Leave Bank and withdrawal of sick time from the Sick Leave Bank is granted by the Committee. Members who are eligible for Sick Leave Bank may request additional time in accordance with the current issue of P&P 1622, Sick Leave Bank.

Members who are eligible for reimbursement of sick or personal leave through the Interim Disability Committee or any other City program should request such reimbursement in accordance with the current Interim Disability Committee policy to ensure that their sick/personal leave is not exhausted.

### **8. FAILURE TO REMAIN IN AUTHORIZED LEAVE STATUS**

Members who fail to remain in an authorized leave status shall be subject to established policy and procedures.

### **9. NOTICE TO DISABILITY PENSION APPLICANTS**

A limited/alternative duty assignment with no reduction in pay or benefits will be offered to sworn members who file an application for a disability pension. Subsequent retirement will have no bearing upon the member's eligibility for a limited/alternative duty position. The Chief of Police has full discretion to revoke any offer of a limited/alternative duty position.

### **10. MANAGEMENT DISCRETION**

Alternative duty assignments remain at the sole discretion of management and are generally utilized on an interim basis.

### **11. MARKED VEHICLES**

Members in an alternative duty status shall not be permitted to participate in the Assigned Vehicle Program. The affected supervisor must notify the Fleet Coordinator of the member's alternative duty status. If the alternative duty is for a period lasting more than 30 days in duration, the vehicle must be turned in to the Fleet Coordinator for retention or reassignment. The assigned shotgun and AR-15 must be turned in to the Quartermaster Unit for retention or reassignment. All mobile computer equipment must be turned in to the Quartermaster Unit for retention or reassignment by the MCT Coordinator.

For alternative duty periods lasting less than 30 days in duration, the vehicle shall be parked at the member's assigned OPD facility until such time as the alternative duty is lifted. The shotgun, AR-15, and mobile computer equipment shall be secured by the member, who is responsible for the safekeeping of the equipment. If it is deemed to be in the best interest of the Agency, the Fleet Coordinator is authorized to make exceptions to this provision as it relates to the vehicle, shotgun, and AR-15. The MCT Coordinator or Mobile Computer Project Manager is authorized to make exceptions to this provision regarding the mobile computer equipment.

## ATTACHMENT A

**ORLANDO POLICE DEPARTMENT  
ON-DUTY INJURIES CHECKLIST**

- Life Threatening – Critical Injury – Go to closest hospital**
- Complete First Report of Injury or Illness form.
  - Call the City's occupational healthcare provider hotline at 407.691.5490 or 1.888.807.1020 and give them all the information on the First Report of Injury or Illness form and make follow-up appointment for the injured employee.
  - Make 3 copies of the First Report of Injury form and distribute to:
    - Original – Payroll
    - Copy – Patrol Services Bureau Aide
    - Copy – Supervisor's file
    - Copy – Give to employee
  - Get a work status on employee from hospital, i.e., full duty, alternative duty, or off work status. (See below)
  - Have employee follow-up with the City's occupational healthcare provider.
  - Document the injury in a report. Distribute with the First Report of Injury form.
- Non-Life Threatening – Serious Injury – Go to Florida Hospital**
- Complete First Report of Injury or Illness form.
  - Call the City's occupational healthcare provider hotline at 407.691.5490 or 1.888.807.1020 and give them all the information on the First Report of Injury or Illness and make follow-up appointment for the injured employee.
  - Make 3 copies of the First Report of Injury form and distribute to:
    - Original – Payroll
    - Copy – Patrol Services Bureau Aide
    - Copy – Supervisor's file
    - Copy – Give to employee
  - Get a work status on employee from hospital, i.e., full duty, alternative duty, or off work status. (See below)
  - Have employee follow-up with the City's occupational healthcare provider.
  - Document the injury in a report. Distribute with the First Report of Injury form.
- Non-Life Threatening – Minor Injuries**
- Call the City's occupational healthcare provider hotline at 407.691.5490 or 1.888.807.1020. They will complete the First Report of Injury or Illness form and make an appointment at the City's occupational healthcare provider for the injured employee.
  - Employee will go to the City's occupational healthcare provider and return with the First Report of Injury or Illness form. Supervisor will put rate of pay on it.
  - Make 3 copies of the First Report of Injury form and distribute to:
    - Original – Payroll
    - Copy – Patrol Services Bureau Aide
    - Copy – Supervisor's file
    - Copy – Give to employee
  - Get a work status on employee from the City's occupational healthcare provider; i.e. full duty, alternative duty, or off work status. (See below)
  - Document the injury in a report. Distribute with the First Report of Injury form.
- Minor Injury – No Treatment Required**
- Complete First Report of Injury or Illness form.
  - Make 3 copies of the First Report of Injury form and distribute to:
    - Original – Payroll
    - Copy – Patrol Services Bureau Aide
    - Copy – Supervisor's file
    - Copy – Give to employee
  - Document the injury in a report. Distribute with the First Report of Injury form.

## ATTACHMENT A (Continued)

## On-Duty Injuries (Con't).

- The City's occupational healthcare provider will release you to:
- Full Duty – Return Directly to Work** (give the City's occupational healthcare provider work status report to Supervisor, copy to Patrol Services Bureau Aide)
  - Alternative Duty – Return Directly to Work** (give the City's occupational healthcare provider work status report to Supervisor, copy to Patrol Services Bureau Aide)\*
    - Get authorization from Division Commander for alternative duty assignment
    - Have Lieutenant serve alternative duty notice (original to Personnel, copy to Patrol Services Bureau Aide).
    - Complete a memo to the Chief of Police requesting alternative duty describing:
      - Injuries and incident
      - Estimated length of alternative duty
      - List of limitations/restrictions
      - Prognosis for recovery
      - Date of MMI (Doctor's diagnosis says that you are as good as you are going to get).
    - Copy of the City's occupational healthcare provider work status report.
    - Forward memo, the City's occupational healthcare provider work status report, and endorsements to the Chief of Police via chain.
    - The Officer must report every 30 days to the City's occupational healthcare provider for evaluation (give the City's occupational healthcare provider work status report to Supervisor, copy to Patrol Services Bureau Aide).
  - Off Work – Go Home** (after giving the City's occupational healthcare provider work status report to Supervisor, copy to Patrol Services Bureau Aide).
    - The Officer must report every 30 days to the City's occupational healthcare provider for evaluation (give the City's occupational healthcare provider work status report to Supervisor, copy to Patrol Services Bureau Aide).
    - When the City's occupational healthcare provider returns the officer to Full or Alternative Duty, follow above instructions for Full or Alternative Duty.

\* If the Officer is returned to alternative duty by the City's occupational healthcare provider, the Officer MUST return to work immediately. The Interim Disability Committee WILL NOT reimburse your time if the Officer elects not to return to work.

Every time an Officer goes to the City's occupational healthcare provider reference this injury, they must immediately give all paperwork to their supervisor and give a copy to the Patrol Services Bureau Aide

If an Officer is referred to a Specialist by the City's occupational healthcare provider, the Officer must immediately give all paperwork to their supervisor and give a copy to the Patrol Services Bureau Aide.

Supervisors are to ensure that info code "Alternative Duty" is selected and applicable time from "Hours Worked" is entered for every day the Officer is on Alternative Duty.

## ATTACHMENT B

## OFF-DUTY INJURIES CHECKLIST

- Off-Duty Injury
- Go to private physician – Do not report to the City's occupational healthcare provider.
- Your Private Physician will release you to:
- Full Duty – Return to Work (give Physician's "Return to Full Duty" statement to supervisor and a copy to Patrol Services Bureau Aide. If there is a question as to whether the Officer can return to full duty, a manager will determine if a fitness for duty evaluation is needed. The fitness for duty evaluation will normally be done by the City's occupational healthcare provider.)
  - Alternative Duty – Do Not Return to Work
    - Private Physician must complete and sign the Request for Alternative Duty Form
    - Complete a memo to the Chief of Police requesting alternative duty describing:
      - Injuries and incident
      - Estimated length of alternative duty
      - List of limitations/restrictions
      - Prognosis for recovery
      - Date of MMI (Doctor's diagnosis says that you are as good as you are going to get)
    - Chain of Command Endorsement Sheet
    - Forward the memo, Request for Alternative Duty Form, and endorsements to the Chief of Police via the chain of command.
    - The Officer must remain in an authorized leave status until the alternative duty request is approved (authorized leave includes sick leave, personal leave, comp time, family leave, authorized no-pay status, etc.)
    - Have Lieutenant serve alternative duty notice (original to Personnel, copy to Patrol Services Bureau Aide)
    - The Officer must be re-evaluated by their physician every 30 days to remain in an alternative duty assignment. (Give physician's Request for Alternative Duty Form to supervisor, copy to Patrol Services Bureau Aide)
- Off Work – Go Home (must remain in an authorized leave status until the Officer can return to work)
- When the physician returns the Officer to Full or Alternative Duty, follow above instructions.

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THE OFFICER MUST HAVE THEIR PRIVATE PHYSICIAN COMPLETE AND SIGN THE REQUEST FOR ALTERNATIVE DUTY FORM EVERY 30 DAYS TO REMAIN IN AN ALTERNATIVE DUTY STATUS. OFFICERS WILL BE SENT HOME IF THIS IS NOT COMPLETED. (Give completed physician's Request for Alternative Duty form to supervisor, copy to the Patrol Services Bureau Aide)

Supervisors are to ensure that info code "Alternative Duty" is selected and applicable time from "Hours Worked" is entered for every day the Officer is on Alternative Duty.



ATTACHMENT C

DATE: \_\_\_\_\_

**MEMORANDUM**

TO: Chief of Police  
VIA: Chain of Command  
FROM: Physician  
SUBJECT: Request for Alternative Duty

The Officer listed on the reverse of this memorandum has requested that I review his/her physical status to determine if they meet the Orlando Police Department's requirements for alternative duty. Their injuries are the result of a "non-line-of-duty" incident occurring on or about \_\_\_\_\_.

I hereby find that the Officer is capable of engaging in the following activities:

1. Respond to nonhazardous calls for service. These include, but are not limited to, investigating traffic accidents, taking reports from victims of crimes where the perpetrator is gone, and other types of calls where no perpetrator is present and no arrest will be made.
2. The ability to write police reports.
3. Interview victims and witnesses.
4. Work shift work.
5. Work 40 hours per week.
6. Be able to ride in a police vehicle and be able to enter and exit the vehicle unassisted.
7. Operate a police radio.

It is additionally expected that the person would have the full use of their mental faculties and be able to see, hear, and speak clearly.

On the reverse side of this form are additional comments which document my evaluation of this Officer's fitness for alternative duty including any specific limitations which I feel are necessary.

ATTACHMENT C (Continued)

MEMORANDUM

NAME OF OFFICER: \_\_\_\_\_ DATE OF INJURY: \_\_\_\_\_

EMPLOYEE ID NUMBER: \_\_\_\_\_

NAME OF PHYSICIAN: \_\_\_\_\_

PHYSICIAN'S ADDRESS: \_\_\_\_\_

PHYSICIAN'S TELEPHONE #: \_\_\_\_\_

DESCRIPTION OF INJURIES AND INCIDENT (PLEASE DESCRIBE IN DETAIL):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ESTIMATED LENGTH OF ALTERNATIVE DUTY: \_\_\_\_\_

ANTICIPATED TREATMENT:

\_\_\_\_\_  
\_\_\_\_\_

LIST OF LIMITATIONS/RESTRICTIONS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DATE OF MAXIMUM MEDICAL IMPROVEMENT: \_\_\_\_\_

\_\_\_\_\_  
PHYSICIAN SIGNATURE

**NOTE: OFFICERS MUST BE RE-EVALUATED BY THEIR PHYSICIAN EVERY 30 DAYS TO REMAIN IN AN ALTERNATIVE DUTY ASSIGNMENT.**

ATTACHMENT D

ORLANDO POLICE DEPARTMENT  
ALTERNATIVE DUTY ASSIGNMENT NOTICE

(Date)

**TO:** \_\_\_\_\_ **EMP. #:** \_\_\_\_\_

**FROM:** \_\_\_\_\_

**SUBJECT:** Alternative Duty Assignment

In accordance with the current issue of P&P 1619, Alternative Duty Assignments, you are hereby placed in an alternative duty status.

On \_\_\_\_\_, at \_\_\_\_\_ hours, you are to report to the \_\_\_\_\_ in civilian attire.

During this period, you are assigned to non-law enforcement duties. You shall not engage in law enforcement extra-duty employment. A member on alternative duty shall not make arrests nor engage in police-related activity requiring a response to resistance, except in the defense of life. Members may carry an approved firearm and police identification in accordance with the current issue of P&P 1702, Firearms and Police Identification.

Should you have any questions concerning your activities while on alternative duty status, you should contact your immediate supervisor.

\_\_\_\_\_  
(Employee's Signature)

The foregoing notice was served personally on \_\_\_\_\_  
(Employee's Name - Printed) / (Employee #)

this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ at \_\_\_\_\_ hours  
(Date) (Month) (Year) (Time)

by: \_\_\_\_\_  
(Section Commander's Signature)

Original: Personnel  Copy: Employee

<b>Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 1</b>		
<b>BEFORE COMPLETING THIS FORM, PLEASE CAREFULLY REVIEW THE INSTRUCTIONS BEGINNING ON PAGE 3</b>		
NOTE: Health care providers shall legibly and accurately complete all sections of this form, limiting their responses to their area of expertise.		
1. Insurer Name:	2. Visit/Review Date: / /	<b>5. FOR INSURER USE ONLY</b>
3. Injured Employee (Patient) Name:	4. Date of Birth: / /	
6. Date of Accident: / /	7. Employer Name	8. Initial visit with this physician? <input type="checkbox"/> a) NO <input type="checkbox"/> b) YES
<b>SECTION I                      CLINICAL ASSESSMENT / DETERMINATIONS</b>		
9. <input type="checkbox"/> No change in Items 9 – 13d since last reported visit. If checked, GO TO SECTION II.		
10. Injury/ Illness for which treatment is sought is: <input type="checkbox"/> a) NOT WORK RELATED <input type="checkbox"/> b) WORK RELATED <input type="checkbox"/> c) UNDETERMINED as of this date		
11. Has the patient been determined to have Objective Relevant Medical Findings? Pain or abnormal anatomical findings, in the absence of objective relevant medical findings, shall not be an indicator of injury and/or illness and are not compensable. <input type="checkbox"/> a) NO <input type="checkbox"/> b) YES <input type="checkbox"/> c) UNDETERMINED as of this date If YES or UNDETERMINED, explain: _____		
12. Diagnosis(es): _____		
13. Major Contributing Cause: When there is more than one contributing cause, the reported work-related injury must contribute more than 50% to the present condition and be based on the findings in Item 11. a) Is there a pre-existing condition contributing to the current medical disorder? <input type="checkbox"/> a <sub>1</sub> ) NO <input type="checkbox"/> a <sub>2</sub> ) YES <input type="checkbox"/> a <sub>3</sub> ) UNDETERMINED as of this date b) Do the objective relevant medical findings identified in Item 11 represent an exacerbation (temporary worsening) or aggravation (progression) of a pre-existing condition? <input type="checkbox"/> b <sub>1</sub> ) NO <input type="checkbox"/> b <sub>2</sub> ) exacerbation <input type="checkbox"/> b <sub>3</sub> ) aggravation <input type="checkbox"/> b <sub>4</sub> ) UNDETERMINED as of this date c) Are there other relevant co-morbidities that will need to be considered in evaluating or managing this patient? <input type="checkbox"/> c <sub>1</sub> ) NO <input type="checkbox"/> c <sub>2</sub> ) YES d) Given your responses to the Items above, is the injury/illness in question the major contributing cause for: <input type="checkbox"/> d <sub>1</sub> ) NO <input type="checkbox"/> d <sub>2</sub> ) YES                      the reported medical condition? <input type="checkbox"/> d <sub>3</sub> ) NO <input type="checkbox"/> d <sub>4</sub> ) YES                      the treatment recommended (management/treatment plan)? <input type="checkbox"/> d <sub>5</sub> ) NO <input type="checkbox"/> d <sub>6</sub> ) YES                      the functional limitations and restrictions determined?		
<b>SECTION II                      PATIENT CLASSIFICATION LEVEL</b>		
<input type="checkbox"/> 14. LEVEL I - Key issue: specific, well-defined medical condition, with clear correlation between objective relevant physical findings and patients' subjective complaints. Treatment correlates to the specific findings.		
<input type="checkbox"/> 15. LEVEL II - Key issue: regional or generalized deconditioning (i.e. deficits in strength, flexibility, endurance, and Motor control. Treatment: physical reconditioning and functional restoration.		
<input type="checkbox"/> 16. LEVEL III - Key issue: poor correlation between patient's complaints and objective, relevant physical findings, indicating both somatic and non-somatic clinical factors. Treatment: interdisciplinary rehabilitation and management.		
<input type="checkbox"/> 17. LEVEL UNDETERMINED AS OF THIS DATE.		
<b>SECTION III                      MANAGEMENT / TREATMENT PLAN</b>		
<input type="checkbox"/> 18. No clinical services indicated at this time.                      If checked, GO TO SECTION IV		
<input type="checkbox"/> 19. No change in Items 20a – 20g since last report submitted.                      If checked, GO TO SECTION IV		
20. The following proposed, subsequent clinical service(s) is/are deemed medically necessary. <b>*** THIS IS A PROVIDER'S WRITTEN REQUEST FOR INSURER AUTHORIZATION OF TREATMENT OR SERVICES. ***</b>		
<input type="checkbox"/> a) Consultation with or referral to a specialist.                      Identify principal physician: _____ Identify specialty & provide rationale: _____ <input type="checkbox"/> a <sub>1</sub> ) CONSULT ONLY <input type="checkbox"/> a <sub>2</sub> ) REFERRAL & CO-MANAGE <input type="checkbox"/> a <sub>3</sub> ) TRANSFER CARE		
<input type="checkbox"/> b) Diagnostic Testing: (Specify) _____		
<input type="checkbox"/> c) Physical Medicine. Check appropriate box and indicate specificity of services, frequency and duration below: <input type="checkbox"/> c <sub>1</sub> ) Physical/Occupational therapy, Chiropractic, Osteopathic or comparable physical rehabilitation. <input type="checkbox"/> c <sub>2</sub> ) Physical Reconditioning (Level II Patient Classification) <input type="checkbox"/> c <sub>3</sub> ) Interdisciplinary Rehabilitation Program (Level III Patient Classification) Specific instruction(s): _____		
<input type="checkbox"/> d) Pharmaceutical(s) (specify): _____		
<input type="checkbox"/> e) DME or Medical Supplies: _____		
<input type="checkbox"/> f) Surgical Intervention - specify procedure(s): _____ <input type="checkbox"/> f <sub>1</sub> ) In-Office: _____ <input type="checkbox"/> f <sub>2</sub> ) Surgical Facility: _____ <input type="checkbox"/> f <sub>3</sub> ) Injectable(s) (e.g. pain management): _____		
<input type="checkbox"/> g) Attendant Care: _____		

**Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 2**

Patient Name: \_\_\_\_\_ D/A: / / Visit/Review Date: / /

**SECTION IV FUNCTIONAL LIMITATIONS AND RESTRICTIONS**  
*Assignment of limitations or restrictions must be based upon the injured employee's specific clinical dysfunction or status related to the work injury. However, the presence of objective relevant medical findings does not necessarily equate to an automatic limitation or restriction in function.*

21. No functional limitations identified or restrictions prescribed as of the following date: \_\_\_/\_\_\_/\_\_\_.

22. The injured workers' functional limitations and restrictions, identified in detail below, are of such severity that he/she cannot perform activities, even at a sedentary level (e.g. hospitalization, cognitive impairment, infection, contagion), as of the following date: \_\_\_/\_\_\_/\_\_\_ . *Use additional sheet if needed.*

23. The injured worker may return to activities so long as he/she adheres to the functional limitations and restrictions identified below. Identify ONLY those functional activities that have specific limitations and restrictions for this patient. Identify joint and/or body part \_\_\_\_\_ *Use additional sheet if needed.*

Functional Activity	Load	Frequency & Duration	ROM/ Position & Other Parameters
<input type="checkbox"/> Bend			
<input type="checkbox"/> Carry			
<input type="checkbox"/> Climb			
<input type="checkbox"/> Grasp			
<input type="checkbox"/> Kneel			
<input type="checkbox"/> Lift-floor > waist			
<input type="checkbox"/> Lift-waist>overhead			
<input type="checkbox"/> Pull			
<input type="checkbox"/> Push			
<input type="checkbox"/> Reach – overhead			
<input type="checkbox"/> Sit			
<input type="checkbox"/> Squat			
<input type="checkbox"/> Stand			
<input type="checkbox"/> Twist			
<input type="checkbox"/> Walk			
<input type="checkbox"/>			
<input type="checkbox"/> Other			

**COMMENTS:** \_\_\_\_\_

Other choices; Skin Contact/ Exposure; Sensory; Hand Dexterity; Cognitive; Crawl; Vision; Drive/Operate Heavy Equipment; Environmental Conditions: heat, cold, working at heights, vibration; Auditory; Specific Job Task(s); etc.

*NOTE: Any functional limitations or restrictions assigned above apply to both on and off the job activities, and are in effect until the next scheduled appointment unless otherwise noted or modified prior to the appointment date.*  
*Specify those functional limitations and restrictions, in Item 23, which are permanent if MMI / PIR have been assigned in Item 24.*

**SECTION V MAXIMUM MEDICAL IMPROVEMENT / PERMANENT IMPAIRMENT RATING**

24. Patient has achieved maximum medical improvement?  
 a) YES, Date: \_\_\_/\_\_\_/\_\_\_  b) NO  c) Anticipated MMI date: \_\_\_/\_\_\_/\_\_\_  
 d) Anticipated MMI date cannot be determined at this time. Future Medical Care Anticipated:  e) YES  f) No  
 Comments: \_\_\_\_\_

25. \_\_\_% Permanent Impairment Rating (body as a whole) Body part/system: \_\_\_\_\_

26. Guide used for calculation of Permanent Impairment Rating (based on date of accident - see instructions):  
 a) 1996 FL Uniform PIR Schedule  b) Other, specify: \_\_\_\_\_

27. Is a residual clinical dysfunction or residual functional loss anticipated for the work-related injury?  
 a) YES  b) NO  c) Undetermined at this time.

**SECTION VI FOLLOW-UP**

28. Next Scheduled Appointment Date & Time: \_\_\_/\_\_\_/\_\_\_ :\_\_\_:\_\_\_m.

**SECTION VII ATTESTATION STATEMENT**

*"As the Physician, I hereby attest that all responses herein have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."* *"I certify to any MMI / PIR information provided in this form."*

Physician Group: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Physician Signature: \_\_\_\_\_ Physician DOH License #: \_\_\_\_\_  
 Physician Name: \_\_\_\_\_ (print name) Physician Specialty: \_\_\_\_\_

**If any direct billable services for this visit were rendered by a provider other than a physician, please complete sections below:**

*"I hereby attest that all responses herein relating to services I rendered have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."*

Provider Signature: \_\_\_\_\_ Provider DOH License #: \_\_\_\_\_  
 Provider Name: \_\_\_\_\_ (print name) Date: \_\_\_/\_\_\_/\_\_\_