

# CITY OF KENOSHA—FIRE DEPARTMENT INDUSTRIAL INJURY OR ILLNESS FORM

To be completed by employee:

Name \_\_\_\_\_ Age \_\_\_\_\_  
Home Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Date of hire \_\_\_\_\_ Job Title \_\_\_\_\_ Shift worked \_\_\_\_\_  
Date and time of injury/illness \_\_\_\_\_  
Nature of injury/illness \_\_\_\_\_  
Attending physician (print) \_\_\_\_\_ Hospital \_\_\_\_\_  
Time Sent to Hospital \_\_\_\_\_ Immediate Supervisor \_\_\_\_\_

" The undersigned requests treatment for the injuries outlined above and hereby gives consent for the physician or hospital to furnish any records of examination, findings, opinions and treatment including x-rays to his/her employer or their insurance carrier."

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

To be complete by Physician after each office visit.

Diagnosis \_\_\_\_\_

X - Rays YES \_\_\_ NO \_\_\_ Results \_\_\_\_\_

Work Related YES \_\_\_ NO \_\_\_ Unable to determine \_\_\_\_\_

Treatment \_\_\_\_\_

Back to Work YES \_\_\_ NO \_\_\_ Date \_\_\_\_\_ Full Capacity YES \_\_\_ NO \_\_\_

Physical Limitations if any

- None
- Lifting limited to \_\_\_\_\_ lbs.
- No lifting
- May do one hand work  Right  Left
- Other

Limited

- Walking  Pushing
- Sitting  Pulling
- Bending  Stretching
- Twisting  Stooping

Duration of limitations \_\_\_\_\_

Follow-up instructions \_\_\_\_\_

Is this employee capable of performing modified or light duty?  YES  NO Please describe limitation \_\_\_\_\_

Physician's Name printed \_\_\_\_\_ Physician telephone # \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

WITHIN 12 HOURS OF OFFICE VISIT RETURN THIS FORM TO:

Fire Chief's Office  
Kenosha Fire Department  
4810-60<sup>th</sup> Street  
Kenosha, Wisconsin 53144  
Fax (262) 653-4107

MEDICAL BILLS TO:

CIVMIC  
9898 W. Bluemound Road  
Wauwatosa, WI 53226-4319