Metropolitan Transportation Authority
POLICE DEPARTMENT

PERSONNEL HEALTH SERVICES FORM

Do not use this form for Service Related Injuries

MEMBER'S INFORMATION (TO BE COMPLETED BY MEMBER)

1. MEMBER'S NAME (PRINT)		2. MEMBER'S SIGNATURE	3. DATE
4. GENDER: ☐ MALE ☐ FEMALE	5. EMPLOYEE I.D. NUMBER	6. COMMAND	7. TOUR/RDO
8. MEMBER'S CONTACT PHONE NUMBER(S):			

DOCTOR'S STATEMENT (TO BE COMPLETED BY PHYSICIAN ONLY)

9. PATIENT'S ILLNESS/INJURY

_____

_____

10..PATIENT'S RESTRICTIONS PREVENT THE FOLLOWING:

- ☐ LIFT (MORE THAN 15 LBS)
- ☐ PUSH (MORE THAN 15 LBS)
- ☐ CLIMB
- ☐ BEND
- ☐ SIT FOR EXTENDED PERIODS OF TIME
- ☐ STAND FOR EXTENDED PERIODS OF TIME
- ☐ OPERATE MOTOR VEHICLE
- ☐ UTILIZE MASS TRANSIT
- ☐ PERFORM REPETITIVE MOVEMENTS
- ☐ OTHER _____

11. PLEASE ENTER THE FOLLOWING DATA:

A. DATE OF FIRST TREATMENT FOR THIS CONDITION _____/_____/_____

B. DATE PATIENT WILL BE ABLE TO PERFORM RESTRICTED WORK _____/_____/_____

C. DATE PATIENT WILL BE ABLE TO PERFORM FULL DUTIES _____/_____/_____

D. NEXT APPOINTMENT DATE/TIME _____/_____/_____

E. PHYSICAL THERAPY PRESCRIBED? ☐ YES ☐ NO IF YES, TIMES PER WEEK _____

12. PHYSICIAN'S NAME (PRINT)	13. PHYSICIAN'S SIGNATURE	14. DATE _____/_____/_____

15. OFFICE ADDRESS:	16. PHONE NUMBER:
	17. FAX NUMBER:

STATEMENT OF INSTRUCTIONS

This Form is required when reporting sick:

- **For Christmas Eve, New Years Eve or any MTA designated holiday**
- **After being denied a request for time off**
- **For three or more workdays**
- **When Classified as Doctor Certified or Chronic**
- **Related to surgery**

FAX COMPLETED FORM TO THE MTAPD MEDICAL CONTROL UNIT AT (212-878-4697)
AND KEEP THE ORIGINAL FOR YOUR RECORDS.