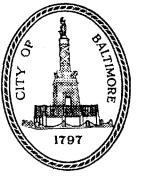


Left Dept. At:

# CITY OF BALTIMORE REQUEST FOR SERVICES (Not for Injury or Acute Services)



All agency information **MUST** be provided with an updated, completed Job Description Summary form.

AGENCY

Date of Request: \_\_\_/\_\_\_/\_\_\_

Employee/  
Candidate Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Department: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Bureau: \_\_\_\_\_ Division: \_\_\_\_\_

Workday Occupation/

Work Tags: \_\_\_\_\_ Job Title: \_\_\_\_\_

Appointment Date for Service: \_\_\_\_\_ Appointment Time: \_\_\_\_\_

SERVICE REQUESTED:	Please check only 1 box.
<input type="checkbox"/> CDL Pre-Placement	<input type="checkbox"/> Non-CDL Pre-Placement Evaluation
<input type="checkbox"/> CDL New Certification	<input type="checkbox"/> Promotion/Transfer Evaluation
<input type="checkbox"/> CDL Re-Certification	<input type="checkbox"/> Fitness for Duty Exam
	<input type="checkbox"/> Return to Work Exam (personal with restrictions)
	<input type="checkbox"/> Medical Surveillance Exam (with studies)
	<input type="checkbox"/> Other (respiratory, audio, etc.) Specify _____

Requested By: \_\_\_\_\_ Job Title: \_\_\_\_\_ Phone: \_\_\_\_\_

Designated HR Authority: \_\_\_\_\_ Job Title: \_\_\_\_\_ Phone: \_\_\_\_\_

CITY OF BALTIMORE OCCUPATIONAL MEDICAL

### Health classification with respect to physical/mental requirements of the job.

- 1. Recommended
- 2. Health related condition(s) exists which may interfere with performance of essential job functions:
  - Lifting limits (weight ranges and frequency) \_\_\_\_\_
  - Sitting (frequency and duration) \_\_\_\_\_
  - Mobility impairment (specify) \_\_\_\_\_
  - Vision impairment (specify) \_\_\_\_\_
  - Hearing impairment (specify ) \_\_\_\_\_
  - Mental Health Needs \_\_\_\_\_
  - Other \_\_\_\_\_
- 3. Deferred pending further evaluation. Due by: \_\_\_\_\_
- 4. Does not meet DOT requirements
- 5. Other \_\_\_\_\_

### Examining Professional

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### Explanation of Classification

1. **Recommended**- This individual is fit for work assignment without apparent need for health related accommodation.
2. **Health related condition(s) exists which may interfere with the performance of essential job functions and may require accommodation**- An individual with a demonstrable physical or mental health condition which may require modifications in the job, environment or manner in which the applicant works and relates to other employees. Where such conditions exist, the medical examiner has listed specific physical and/or mental activities that are of concern for the applicant. If an individual is originally hired under this Health Classification, it is imperative that the employee be re-examined before promotion or job reassignment if the new assignment includes job requirements involving previously listed restrictions.
3. **Deferred pending further evaluation**- The information available is insufficient to determine whether or not this individual's impairment allows the performance of the essential functions of the job. Additional medical information is necessary.

This assessment was performed \_\_\_ with \_\_\_ without a written statement describing the essential functions of the job.

- Requestor removes only the last copy.
- 1) Original – Medical Services    2) Medical Services    3) Safety    4) Designated HR Authority