DISCLOSURE OF PRESCRIPTION DRUGS

CONFIDENTIAL

INSTRUCTIONS FOR EMPLOYEE

1. Complete this form **ONLY** if you need to disclose a prescription drug that may impact your job performance.
2. Have your health care provider complete the Health Care Provider section.
3. Return this form to the hiring Department.
4. This information will only be used to determine if a prescription drug may impact the job performance of an employee whose job has been designated 'safety-sensitive.'

TO BE COMPLETED BY EMPLOYEE

I hereby authorize my health care provider to disclose to Werkman Transport specific health information - use of any prescription drug that may impact my job performance in the safety-sensitive position of Class 1 Driver

Employee's Printed Name _____ Date _____

Employee's Signature _____

This authorization is valid during the duration of my employment or the expiration of the prescription whichever is earlier.

TO BE COMPLETED BY HEALTH CARE PROVIDER

I,_____ am aware of the job duties of _____ as a
Health Care Provider's Name Patient Name

Class 1 Driver with Werkman Transport.

I have prescribed for this employee the medication(s) listed below (*Please write legibly)*:

Name of Medication: _____ Dosage: _____ Duration to be taken: _____

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Name of Medication: _____ Dosage: _____ Duration to be taken: _____

It is my opinion that if taken as directed the medication (*check one*):

[ ] will not impair [ ] will impair the employee's ability to perform his/her job safely.

Health Care Provider's Signature _____ Health Care Provider's Phone Number _____

Health Care Provider's Printed Name _____ Date _____

If you have additional prescriptions, please use the back of this form.