

# Prescription Drug and Over-the-Counter Medication Disclosure Form

Employees who are authorized to operate a motor vehicle, and/or are in safety sensitive positions, are required to advise their supervisor whenever they work while taking a legal drug that may have adverse effects.

This form should be returned to the Human Resources Manager, via your Supervisor, upon completion.

Employee Name: _____	Date: _____	
Immediate Supervisor: _____		
Is employee in safety sensitive position?	<input type="checkbox"/> Yes	If yes, Job title: _____
	<input type="checkbox"/> No	
Employee authorized to operate motor vehicle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

1. Name of Medication: \_\_\_\_\_  
 Prescribed by licensed physician Date: \_\_\_\_\_ Physician: \_\_\_\_\_  
 Over-the-Counter medication  
 Other: \_\_\_\_\_  
Date medication treatment expected to be completed: \_\_\_\_\_
2. Name of Medication: \_\_\_\_\_  
 Prescribed by licensed physician Date: \_\_\_\_\_ Physician: \_\_\_\_\_  
 Over-the-Counter medication  
 Other: \_\_\_\_\_  
Date medication treatment expected to be completed: \_\_\_\_\_
3. Name of Medication: \_\_\_\_\_  
 Prescribed by licensed physician Date: \_\_\_\_\_ Physician: \_\_\_\_\_  
 Over-the-Counter medication  
 Other: \_\_\_\_\_  
Date medication treatment expected to be completed: \_\_\_\_\_

**I agree to immediately notify the Company of any increase in the dose or frequency of the above disclosed medications.  
I also agree to immediately notify the Company of any change or addition of covered medication.**

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

Human Resource Signature: \_\_\_\_\_ Date: \_\_\_\_\_