SAFETY SENSITIVE EMPLOYEE DRUG REPORT (MD1000)

TO BE COMPLETED BY EMPLOYEE

Employee Information

Name: ______________________________ IHB ID#: ____________

Address: ______________________________

City: ____________________ State: __________ Zip: __________

Email address: ______________________________ Phone: ____________

Department: ____________________ Job Title: ____________________

Is job safety sensitive? Yes ________ No ________

I authorize the IHB to contact my provider to obtain clarification regarding the responses provided on this form and/or to discuss my prescription medication as it relates to my ability to safely perform my safety sensitive job duties only.

Yes __________ No __________

I authorize my provider to speak with the IHB regarding this form and my prescription medication as it relates to my ability to safely perform my safety sensitive job duties only.

Yes __________ No __________

______________________________ ______________

Employee Signature Date

TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER

Physician Information

Name: ______________________________

Type of Practice: ______________________________

Address: ______________________________

City: ____________________ State: __________ Zip: __________

Email address: ______________________________

Phone: ____________________ Fax: ____________________

The above named patient is under my treatment for: ______________________________

____

The above named patient has been prescribed the following drug(s) : ______________________________

____

Do you have knowledge of the patient's safety sensitive job duties at work? Yes ______ No ______

Have you received a copy of the patient's functional job description? Yes ______ No ______
(If no, please ask the patient or contact the Manager of HR/LR at 219-989-4850 and we will provide you with one)

For each drug listed above, please complete drug information page. If more than one drug has been prescribed, complete a separate drug information page for each drug.

______________________________ ______________

Provider's Signature Date

MD1000-DRUG INFORMATION PAGE

TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER

Patient name: ______________________________

The above named patient has been prescribed the following drug: ______________________________

The above named drug has been prescribed to treat: ______________________________ (condition)

List administration type, dosage and frequency of the drug: ______________________________

____

Possible side effects of this drug include: ______________________________

____

____

If the above named patient has already begun taking the above listed medication;

On what date did the patient begin use of the above listed drug(s)? ______________________________

On what date will the patient stop use of the above listed drug? ______________________________

Does this patient experience any side effects from the above listed drug that could effect his/her ability to safely perform their job duties, even in cases of safety sensitive job duties? Yes_______ No________

If yes, list side effects experienced here: ______________________________

____

If the above named patient has NOT already begun taking the above listed medication;

On what date will the patient begin use of the above listed drug? ______________________________

On what date will the patient stop use of the above listed drug? ______________________________

Could the use of this drug have an effect on the patient's ability to perform his/her job in a SAFE manner in cases of safety sensitive job duties? Yes__________ No__________ Unknown __________

Additional Comments: ______________________________

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______________________________ ______________

Provider's Signature Date

Return this form to the IHB Human Resources Department, 2721-161st Street, Hammond, IN 46323, or fax to 219-989-4967