



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: _____

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