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

MD1000-DRUG RECOMMENDATION PAGE

TO BE COMPLETED BY IHB'S MEDICAL CONSULTANT

Patient name: _____

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

Based on the information provided to me by the IHB regarding the employee's job functions, the employee's healthcare provider regarding the drugs prescribed, and my medical knowledge, the following is my recommendation regarding the employee's use of this drug;

_____ I have reviewed the drug prescribed for the above named employee. This drug will not effect his/her safe and effective performance on the job.

_____ I have reviewed the drug prescribed for the above named employee. This drug may effect his/her safe and effective performance on the job. (See explanation below)

_____ Additional information is needed in order for a determination to be made. (See explanation below)

Comments: _____

_____ _____

IHB Medical Consultant's Signature Date