EMPLOYEE PRESCRIPTION DRUG REPORT

Employee's Information:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
ID No: _____ Phone No: _____
Position: _____ Dept: _____

Physician's Information:

Name: _____
Address: _____
_____
City: _____ State: _____ Zip Code: _____
Phone No: _____ Fax No: _____

I authorize the above medical professional to release medical information to the IHB RR regarding my illness, injury, or work status, and additionally, authorize the IHB RR to contact the physician above for further information, if required.

_____ Date

_____ Employee's Signature

IHB PRESCRIPTION DRUG WAIVER

The above named employee is under my treatment for: _____

And has been prescribed the following medications: _____

The side effects of this/these drug(s) are: _____

[A] _____ They will have no effect on the ability to perform his/her job in a safe and effective manner.

[B] _____ The above named employee can be expected to be on this medication until: _____

_____ Date

_____ Personal Physician's Signature

IHB MEDICAL DIRECTOR'S REVIEW

[A] _____ I have reviewed the prescription recommended for the above named employee. This pharmaceutical treatment will not affect his/her performance on the job.

[B] _____ I have reviewed the pharmaceutical treatment recommended for the above named employee and feel the drug may affect his or her safe and effective job performance. I have consulted with the employee's personal physician and the following drugs are recommended as an acceptable substitute: _____

_____ Date

_____ IHB Medical Director's Signature

Return this form to the IHB Human Resources Department, 2721-161st Street, Hammond, IN 46323-1099, or fax this form to 219/989-4967.