



### EMPLOYEE PRESCRIPTION DRUG REPORT

*Employee's Information:*

*Physician's Information:*

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

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.**