SAFETY SENSITIVE EMPLOYEE DRUG REPORT (MD1000)

TO BE COMPLETED BY EMPLOYEE

Employee's Information:

Name: _____ IHB ID# _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone # _____ Email: _____

Position: _____ Dept. _____

Safety Sensitive? _____ Yes _____ No

Physician's Information:

Name: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Phone No: _____ Fax No: _____

Email:

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

_____ _____

Employee Signature Date

TO BE COMPLETED BY HEALTH CARE PROVIDER

The above named employee is under my treatment for: _____

And has been prescribed the following drug(s): _____

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

On what date do you anticipate that the employee will begin using this/these drug(s)? (answer seperately for each drug) _____

The use of this/these drug(s) will have no effect on the ability to perform his/her job in a safe and effective manner, even in cases of safety sensitive job duties. YES _____ NO _____

To my knowledge, the employee DOES _____ DOES NOT _____ perform safety sensitive duties at work.

I have received and reviewed a functional job description for the employee's position: YES _____ NO _____

On what date do you anticipate that the employee will stop using these drug(s) (answer separately for each drug)?: _____

_____ _____

Provider's Signature Date

TO BE COMPLETED BY IHB MRO

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

_____ I have reviewed the drug(s) prescribed for the above named employee. This/these drug(s) may affect his/her safe and effective performance on the job.

_____ If the employee had been prescribed this/these comparable drug(s), it would change my opinion whether he/she could safely and effectively perform the job.

Comments: _____

_____ _____

IHB Medical Review Officer's Signature Date

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