CONFIDENTIAL

DISCLOSURE OF PRESCRIPTION DRUGS

INSTRUCTIONS FOR EMPLOYEE

1. Complete this form **only** if you need to disclose a prescription drug that may impact your job performance.
2. Have your health care provider complete the Health Care Provider section.
3. Return this form to your supervisor or the Division designee.
4. This information will only be used to determine if a prescription drug may impact the job performance of an employee whose job has been designated 'safety sensitive.'
5. This form shall be kept in a separate, secure medical file and will not be placed in your personnel file.

TO BE COMPLETED BY EMPLOYEE

I hereby authorize my health care provider to disclose to Salt Lake County specific health information - use of any prescription drug that may impact my job performance in the safety sensitive position listed below

Employee's Signature

Employee's Division and Job Title

Employee's Printed Name

Date

This authorization will expire on the following date, event or condition:

I understand if I do not specify a date, event or condition, this authorization is valid during the duration of my employment or the expiration of the prescription whichever is earlier.

TO BE COMPLETED BY HEALTH CARE PROVIDER

I, Health Care Provider's Name am aware of the job duties of

with Salt Lake County. I have prescribed for this employee the medication(s) listed below (*Please write legibly*):

Name of Medication: Dosage: Duration to be taken:

Name of Medication: Dosage: Duration to be taken:

It is my opinion that if taken as directed the medication (*check one*):

☐ will not impair ☐ will impair the employee's ability to perform his/her job safely.

Health Care Provider's Signature

Health Care Provider's Telephone Number

Health Care Provider's Printed Name

Date

If you have additional prescriptions, please complete the back of this form.

Form to be placed in secure medical file.

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TO BE COMPLETED BY HEALTH CARE PROVIDER

Name of Medication:		Dosage:		Duration to be taken:	
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It is my opinion that if taken as directed the medication (*check one*):

☐ will not impair ☐ will impair the employee's ability to perform his/her job safely.

Health Care Provider's Signature

Health Care Provider's Telephone Number

Health Care Provider's Printed Name

Date

MRO Review

Agree with physician's opinion ☐ Yes ☐ No

Comments:

Signature

Date

Form to be placed in secure medical file.