Prescription Drug Use Form for Safety Sensitive Employees

Instructions: As required by WTA Fit For Work Policy report any prescription medications that may impair your ability to safely perform your job. This includes medications that may cause drowsiness, medications with warnings not to use while driving, and medications with warnings to use with caution while operating machinery. Report new prescriptions and any changes to your prescriptions.

Complete the employee section and take form to your prescribing Health Care Provider. Once completed, submit original form to the Human Resources Department or send through confidential fax (Fax: 360-715-4518). Once received it will be retained in your confidential medical file.

Employee Section:

Employee Name:_____ Job Position:_____

Employee's Safety-Sensitive Job Function – Check those that apply:

☐Operate a transit bus in or out of revenue service

☐Operate a non-revenue service vehicle requiring a commercial driver's license

☐Control the dispatch or movement of transit buses

☐Maintain/repair transit buses

Authorization:

- I understand that my status of a CDL holder and/or safety sensitive position requires me to inform WTA of any medication I am taking which may cause motor or mental function impairment.
- I also recognize that it is my obligation to inform my physician of my job duties at WTA.

Employee Signature_____Date_____

Health Care Provider Section*: Please print legibly*

Name of Drug **Treatment Start/End Date**

1. _____ _____

☐Employee released to perform safety-sensitive duties while taking this medication .

☐Employee may not perform safety-sensitive duties while taking this/these medication(s).

☐Employee should not take during or for _____hours before duty.

Please note any other restrictions:

__ __

Name of Drug **Treatment Start/End Date**

2. _____ _____ _____

Employee should not take during or for _____hours before duty.

☐Employee released to perform safety-sensitive duties while taking this medication .

☐Employee may not perform safety-sensitive duties while taking this/these medication(s).

☐Employee should not take during or for _____hours before duty.

Please note any other restrictions:

__ __

I have reviewed the above named employee's current medical condition, and I am familiar with the employee's job duties. This patient is currently under my medical supervision, and this is my best medical opinion.

Health Care Provider Signature_____Date_____

Name and Title_____Phone_____