



TDOT MEDICATION APPROVAL FORM

EMPLOYEE COMPLETES THIS SECTION:

EMPLOYEE NAME _____ DATE _____

EMPLOYEE ID # _____ JOB TITLE _____

JOB DESCRIPTION _____

REGION _____ WORK PHONE NUMBER: _____ OTHER NUMBER _____

Name of Drug	Date Prescribed	Date Approval Expires	Restrictions/Instructions
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

The information provided in this Medication Approval Form is true and correct to the best of my knowledge. I understand and will comply with the prescribed use of these medications and their restrictions while working.

Signed _____ Date _____

EMPLOYEE'S HEALTH CARE PRACTITIONER COMPLETES THIS SECTION:

Please complete this form so that your patient can work in his/her Tennessee Department of Transportation safety sensitive job. By signing below, you are acknowledging that you are aware of this employee's job duty requirements and that the prescribed medication(s) currently being taken will not adversely impair performance or endanger the safety of this individual, co-worker, or the public. Please indicate below what, if any, restrictions should be placed upon the time between when the medication is taken and the time the individual can safely perform his/her job duties.

Medication Employee is Currently Taking:

Name of Drug	Date Prescribed	Date Approval Expires	Restrictions/Instructions
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signed _____ Date _____

Please Print Name, Address and Phone Number Below:

