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.

_____ _____

Employee Signature / Employee ID # / Phone Number 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:

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