MEDICATION DECLARATION FORM

Background information: The bearer of this form is an employee of the State, who, by union agreement, is required to inform the State (employee's supervisor) of the use of controlled substances while working except as prescribed by a physician and is used in accordance with the physician's instruction. The physician must also inform the employee (patient) if the medication will or will not adversely affect the employee's ability to work and work in a safe manner so as not to injure the employee or others. If not reported the employee may be subject to discharge

Employee:____________________________ Department:_________________________

Division:_____________________ Supervisor: ________________Phone: ____________

Medication: _______________ Drug Class (narcotic, depressant, etc.): _______________

Common drug name: ____________________ OTC medication? Yes: ____ No: ____

Dosage: ________ Frequency: _____________ Initial prescription date: _____________

☐ The substance will adversely affect the employee's ability to work in a safe manner (to self and others), including activities such as: operating a motorized or electrical equipment or vehicle, or affect mental capacity to discern right and wrong or the proper use force, weapons, etc.

☐ The substance will not adversely affect the employee's ability to work in a safe manner so as not to injure self or others in activities as illustrated above.

Physician: (print): ___________________________ Signature: ____________________

Company: _________________________________ Phone number: ______________

Address: ______________________________________ Suite number: ____________

City: _____________________ State: _______________ Zip Code: ______________

Note: **the use of hemp products will not invalidate a positive drug test result.**

Department use only

Date received: ____________ Received by: ____________________________________