**\_\_\_\_\_\_\_\_\_ COUNTY ROAD COMMISSION**

**SAFETY-SENSITIVE EMPLOYEE RELEASE TO WORK FORM**

**FOR PRESCRIPTION MEDICATIONS**

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**1.** EMPLOYEE: Complete the “Employee’s Section” on the reverse side of this form and provide the form to your prescribing physician for completion of the “Physician’s Section.”

**2.** PHYSICIAN: Please consider the following information and complete the “Physician’s Section” on the reverse side of this form. Thank you for your assistance.

CONSIDERATIONS

1. The following list of medications of concern if used while performing safety-sensitive work is not definitive or all-inclusive but is provided as a starting point for your consideration.

**Analgesics**

Aspirin w/codeine, Codeine, Demerol, Dilaudid, Empirin Compound w/codeine, Levo-Dromoran, Methadone, Morphine, Percocet, Percodan, Soma Compound w/codeine, Talacen, Talwin, Tylenol w/codeine, and Vicodin.

**Anti-Motion Sickness**

Antivert, Dramamine, Marezine, Phenergan, Transderm-Scop.

**Tranquilizers & Sedatives**

Ativan, Centrax, Compazine, Dalmane, Diazepam, Equanil, Halcion, Haldol, Libritabs, Librium, Limbitrol, Paxipam, Phenergan, Prolixin, Serax, Stelazine, Thorazine, Tranxene, Valium, Valrelease, Xanax.

**Antidepressants**

Adapin, Amitriptyline, Asendin, Deproloft, Desyrel, Elavil, Endep, Etrafon, Limbitrol, Lithium, Ludiomil, Marplan, Nardil, Norpramin, Pamelor, Parnate, Pertofrane, Sinequan, Surmontil, Tofranil, Vivactil.

**Barbiturates**

Alurate, Butisol, Dilantin, Mebaral, Nembutal, Pentobarbital, Secobarbital, Seconal, Sedapap, Tuinal.

**Skeletal Muscle Relaxants**

Flexeril, Parafon, Soma.

**Non-Prescription Cough & Cold Remedies, Antihistamines**

Benadryl, Bromfed, Chlortrimeton, Comtrex, Contac, Deconamine, Dimetapp, Dristan, Drixoral, Extendryl, Fedahist, Kronofed, Naldecon, Nolamine, Novafed, Ornade, Phenergan, Rondec, Rynatan, Sinubid, Sinulin, Tavist-D.

1. The employee should not be released to work unless you are comfortable that, given the safety-sensitive nature of this patient’s job duties, his/her medical history, current condition and possible side effects of the prescribed medication(s), it is your professional opinion that the medication(s) will have no adverse influence on the employee’s performance of his/her safety-sensitive job duties.

**RELEASE TO WORK FORM FOR PRESCRIPTION MEDICATIONS**

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**Employee’s Section:**

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# XXX-XX-\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee’s Safety-Sensitive Job Function – check those that apply.

\_\_\_ Operate a vehicle requiring a commercial driver’s license.

\_\_\_ Control the dispatch or movement of vehicles requiring a commercial driver’s license.

\_\_\_ Maintain/repair vehicles requiring a commercial driver’s license.

\_\_\_ Supervisor whose duties require the performance of any of the above

functions. (Check those that apply)

Medication(s) currently being taken \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I attest that the foregoing information is complete and correct.

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

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**Physician’s Section:**

As the attending physician, I have prescribed the following medication(s) to be taken from \_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Medication Dosage

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Medication Dosage

**(PLEASE CHECK ONE OF THE FOLLOWING)**

\_\_\_\_ Employee may not perform safety-sensitive duties while taking this medication.

(Employee – give form to your supervisor.)

\_\_\_\_ Employee released to perform safety-sensitive duties while taking medication.

(Employee – keep form on your person while at work.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Printed Name Telephone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date