MARANA AZ
HUMAN RESOURCES

EMPLOYEE DISCLOSURE OF PRESCRIPTION DRUGS

INSTRUCTIONS FOR EMPLOYEE

1. Complete this form only if you need to disclose a prescription drug that may impact your job performance.
2. Submit the completed form to your supervisor.
3. Supervisor shall forward this form to Human Resources
4. This form shall be kept in a separate, secure medical file and will not be placed in your personnel file.

TO BE COMPLETED BY EMPLOYEE

I attest that I am currently under a physician's care and have been prescribed medication, which if taken as directed, will impair my ability to perform my job safely.

Duties impacted_____

_____

Duration to be taken:_____

Employee Division and Job Title

This notice will expire on the following date, event or condition_____

_____

I understand if I do not specify a date, event or condition, this authorization is valid during the duration of my employment or the expiration of the prescription whichever is earlier.

_____	_____
Employees Printed Name	Supervisors Printed Name
_____	_____
Employees Signature	Supervisors Signature
_____	_____
Date	Date

Form to be placed in secure medical file.