CITY OF HARRODSBURG
DRUG FREE WORKPLACE
POTENTIAL PERFORMANCE ALTERING
PRESCRIPTION DRUG NOTIFICATION FORM

Employee Name: ____

Department: ________________________

Employee Position: ____

Doctor's Care ______ **Medication Prescribed Under Doctor's Care**

Prescribing Physician _____________________________________
(Please Print)

Elected for Myself ______ **Over-the-Counter Medication**

	Prescription/Over-the-Counter Medication – Name/Dosage	Start Date	Duration
1.	________________________	__________	__________
2.	________________________	__________	__________
3.	________________________	__________	__________
4.	________________________	__________	__________
5.	________________________	__________	__________

____________**By completing this form, I am notifying the City Harrodsburg of medication(s) which may temporarily alter my ability to perform my assigned duties in accordance with the City's Drug Free Workplace Policy.**

___________**I am aware that I am responsible for consulting the prescribing physician and I have attached a letter from my Doctor stating whether the medication may interfere with safe performance of my High Safety Awareness Level job duties.**

____
Employee Signature **Date**

____
Supervisor Signature **Date**

This form will be filed in Human Resources under the HIPPA guidelines