CITY OF MURRAY, KENTUCKY
DRUG & ALCOHOL-FREE WORKPLACE
PRESCRIPTION DRUG NOTIFICATION FORM
FOR HSAL EMPLOYEES

Employee Name: _____

Department

_____

Employee Position:

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

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

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

Approval/Disapproval: 1._____ 2. _____ 3. _____ 4. _____5. _____ (for Director's use only--"y" for yes, "n" for no)

By completing this form, I am notifying the Director OF Human Resourceas of medications that may alter my job performance in accordance with the Department's Drug & Alcohol-Free Workplace Policy.

_____
Employee Signature **Date**

**********For Human Resource Director's Use Only***********

Date Received: _____ Date Forwarded to City's Physician_____

Physician's Comments:

_____
Director or Authorized Representative **Date**