

# SRP Commercial Driver Medication Form

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**Employee:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name Print**

**Signature**

**\*\*By signing above I authorized the physician below to forward this form to SRP Health Services\*\***

**Reported Medication:** \_\_\_\_\_

SRP requires if a driver undergoes prescribed medical treatment, the driver is to report this treatment to his/her supervisor and have the prescribing physician verify the medication will not impair performance or affect safety-sensitive work.

The employee named above has disclosed that you are the treating doctor prescribing the above medication.

As part of the physical qualifications for drivers under 49 CFR Part 391.41, a person shall not drive a commercial motor vehicle unless the individual is physically qualified to do so. Additional requirements under 391.41(b)(12)(i) require that the individual does not use a controlled substance identified in 21 CFR 1308.11 Schedule 1, an amphetamine, a narcotic, or any other habit-forming drug except as authorized by a licensed physician who is familiar with the driver's medical history and assigned duties and has advised the driver that the prescribed substance or drug will not adversely affect the driver's ability to safely operate a commercial motor vehicle and perform safety-sensitive duty. **Please verify below that the medication taken will not impair performance or endanger the safety of the individual worker, SRP customers, or the public.**

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**Please verify by marking one the following:**

- I verify that the medication listed above carries no side effects of sedation, somnolence, and dizziness, slowed reaction time or altered consciousness that could affect safety-sensitive duty, and will not affect the driver's ability to safely operate a Commercial Motor Vehicle.**
- The employee should not perform safety-sensitive function at the present time until further notice.**
- The condition for which this medication was prescribed has resolved or improved to the point that I no longer authorize the employee to take the above medication.**

\_\_\_\_\_  
**MD/DO**

**Print Name**

**Signature**

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Please return this form to SRP Health Services, Mail Station PAB 260, P.O. Box 52025, Phoenix, AZ 85072-2025. You may fax this to SRP Health Services **Confidential Fax at 602-236-5906**. If you have any questions, please contact SRP Health Services at 602-236-5956.

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