

18. Drug and Alcohol-Free Workplace Policy and Procedure

**Medications Disclosure Form for Mississippi Employees/Applicants**

You are required to disclose information about prescription drugs or over-the-counter medications you are taking which adversely affect, or which may reasonably be expected to adversely affect, your ability to effectively perform your job in a safe and productive manner. This disclosure shall be submitted to Company's designated Medical Review Officer (MRO), and shall otherwise be kept confidential and will only be released to others on a need-to-know basis.

Employee/Applicant Name: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_

Prescribing Physician's Name: \_\_\_\_\_

Prescribing Physician's Address: \_\_\_\_\_

Prescribing Physician's Telephone Number: \_\_\_\_\_

Name of Drug: \_\_\_\_\_

Date of Prescription: \_\_\_\_\_ Length of Time on Prescription: \_\_\_\_\_

Over-the-Counter Medication Name: \_\_\_\_\_

Describe the safety-related side-effects you have been warned about or you have had as a result of using this drug or over-the-counter medication (attach additional pages if needed): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**THIS DOCUMENT DOES NOT CREATE A CONTRACT OF EMPLOYMENT**