





U.S.  
Occupational Health  
Resources

*EHS*

**Fitness for Duty Form**

**OTHER RESTRICTIONS / COMMENTS**

**(6) MEDICATION RESTRICTIONS:**

Has employee been prescribed medication(s) that may cause a possible workplace safety concern and / or a driving issue (e.g. drowsiness or mood altering)?

- NO**
- YES**

**Please list medication(s) and possible effects associated with each:**

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**If YES**, will the medication impact the employee's ability to work safely during working hours?

- YES**
- NO**
- Advised to take alternate treatment while at work. **Please describe:**

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**LHCP Name:** \_\_\_\_\_ **LHCP Signature:** \_\_\_\_\_

**LHCP Phone:** \_\_\_\_\_ **LHCP Fax:** \_\_\_\_\_

**Follow-up Appointment:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**GINA disclaimer:** We are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.