FITNESS FOR DUTY - MEDICAL CLEARANCE TO RESUME DUTY

(Medical information is CONFIDENTIAL)

Clear

INSTRUCTIONS TO THE DRIVER: Please take this form to the medical professional most familiar with your health history, current prescription medication use and current medical condition. **Before** giving this form to your medical professional, complete and sign Section 3.

INSTRUCTIONS TO THE MEDICAL PROFESSIONAL: Please complete Sections 4-5, indicate your professional medical opinion within Section 5, sign & stamp, then e-mail this document to: ***mro@fdtsi.com*** for payment processing.
Our employer records indicate your patient may be taking a prescribed medication that could effect the safe operation of a motor vehicle and/ or the performance of hazardous work-related tasks. In this case, the requesting employer is very concerned about the following issue:
- PATIENT/EMPLOYEE'S USE and/or CONTINUED USE OF IMPAIRING PRESCRIPTION MEDICATIONS.

SECTION 1 — DRIVER/PATIENT INFORMATION

Rx Substance(s) Creating Safety Concern:

NAME (LAST, FIRST, MIDDLE)	DRIVER LICENSE NO.	BIRTH DATE	**EMPLOYER NAME:**

STREET ADDRESS	CITY	ZIP	**D.E.R. NAME & PHONE:**

SECTION 2 — DRIVER/PATIENT ADVISORY STATEMENT

This information is required under the employer's written policy, in order to determine your fitness to safely perform within a hazardous or *"Safety-Sensitive"* work environment. Failure to provide this information is a violation of company policy & may result in termination.

All employer records, relating to this fitness for duty evaluation are strictly confidential and not open to public inspection. Information obtained will only be used to determine your ability to safely operate a motor vehicle or perform "*Safety-Sensitive*" job functions for the employer.

SECTION 3 — RELEASE OF MEDICAL INFORMATION TO MY EMPLOYER & C/TPA

EMPLOYER/THIRD PARTY ADMINISTRATOR'S NAME:	D.E.R. NAME:	SECURED E-MAIL:

DATE:	BILLING ADDRESS:

I hereby authorize my medical professional, doctor, nurse, hospital, urgent care or any other medical facility/person with direct knowledge of my recent medical and/or prescriptive drug use history to perform and complete this fitness for duty evaluation, and render their professional medical opinion as to my ability, or inability, to safely operate a motor vehicle or safely perform *"Safety-Sensitive"* duties, while taking the prescription medications referenced within my private patient medical records kept within your facility. This release of confidential medical records shall be valid for 90 days from the date of my signature below. Scan/Copied/Fax reproductions shall be treated as an original.

SIGNED	DATE
X	

SECTION 4 — MEDICAL PROFESSIONAL'S MEDICAL EVALUATION INSTRUCTIONS

INSTRUCTIONS TO THE MEDICAL PROFESSIONAL (MP):

Your experience and knowledge of the patient's condition, results of medical examinations, prescriptive drug use and treatment plans, will be of great value in assisting the employer in determining what job functions this employee can safely perform, while under your direct care. During your one-on-one, confidential assessment with your Patient, please consider all possible side affects that can negatively influence your patient's safe operation of a motor vehicle or daily performance of other "*Safety-Sensitive"* job functions. Upon completion of your Patient evaluation PLEASE MAKE YOUR PROFESSIONAL MEDICAL OPINION BELOW on this form, then e-mail signed form to: ***mro@fdtsi.com***. Thank you for helping to keep our roadways, and workplaces safer for all!

SECTION 5 — PROFESSIONAL MEDICAL OPINION/DETERMINATION

IS THIS DRIVER/PATIENT CURRENTLY UNDER YOUR CARE?

☐ Yes ☐ No. *If this Driver/Patient is **not** currently under your professional care please deny services and send this Patient to their Primary Care Physician.*

☐ This Driver is currently prescribed a prescription medication that has the potential to cause physical or mental Impairment. In my professional medical judgment, this Patient should not be operating a motor vehicle or performing "Safety-Sensitive" duties, until this patient's course of treatment has concluded (**NOT SAFE TO OPERATE A MOTOR VEHICLE AT THIS TIME**).

☐ This Driver is currently prescribed a prescription medication that has the potential to cause physical or mental Impairment. HOWEVER, in my professional medical judgment, this Patient should be able to safely operate a motor vehicle or perform "Safety-Sensitive" duties, during this patient's course of treatment. (**DEEMED SAFE TO OPERATE A MOTOR VEHICLE AT THIS TIME**).

MEDICAL EVALUATOR'S ADDITIONAL REMARKS *(One of the Two Determination Boxes **MUST** be checked above):*	**AFFIX DOCTOR'S ADDRESS STAMP** *(Below)*

MP'S SIGNATURE	MP'S NAME *(PRINTED)*	DATE COMPLETED:
X		

CLASSIFICATION OR SPECIALTY	MEDICAL LICENSE NUMBER	TELEPHONE NUMBER
		( )