ALASKA RAILROAD

Exhibit B

Clinic Name
Street Address
City, State zip code
Phone: (907) xxx-xxxx / Fax: (907) xxx-xxxx

Prescription Review Form

Name: _____ Position: _____

Today's Date: _____ Date of birth: _____ Phone Number(s):_____

Please provide all prescription medication(s) that you are presently taking that could adversely affect your alertness, coordination, reaction, response, or safety on the job. This is intended to include any over-the-counter medications obtained outside of the United States, which could also adversely affect an employee.

Name of Medication	**Dosage & Frequency Taken**	**Date you began taking Prescription**

Are you experiencing any side effects from this medication? Yes ☐ No ☐

If yes, list all side effects you are experiencing: _____

Employee Signature: _____

Human Resources (HR) will fax this form to the clinic named above. The bottom portion will be completed, signed by the medical provider, and returned by fax to HR. HR will notify the employee and/or supervisor of the results.

I have reviewed the above prescription drugs and the medical requirements for the above position.

☐ This employee **IS RELEASED** with no restrictions while taking the above medication.

☐ This employee **IS NOT RELEASED** for duty while taking the above medication.

Employee must wait _____ hours after last dosage before returning to work.

_____

_____

Medical Provider Signature: _____ Date: _____

Printed Name: _____