

Authorization to Work with Medication(s)*

*Medication(s) that may interfere with safe work performance.

Employee: Complete and sign the top portion of this form and give it to your physician.

Employee Name	Employee ID
Current job title:	Current Work Location (city/state)

Check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Operate a train

<input type="checkbox"/> Control the dispatch of trains/power director

<input type="checkbox"/> Carry firearms for security purposes

<input type="checkbox"/> Construct/maintain signal systems

<input type="checkbox"/> Operate equipment

<input type="checkbox"/> Crew dispatcher/clerical | <input type="checkbox"/> Operate a forklift or a vehicle requiring a commercial drivers license

<input type="checkbox"/> Maintain/repair trains or the electromechanical systems controlling their movement

<input type="checkbox"/> Maintain/repair the right-of-way

<input type="checkbox"/> On board food service/train attendant

<input type="checkbox"/> Work on or about trains/moving equipment

<input type="checkbox"/> Management/administrative |
|--|--|

Medications and/or over-the-counter substances currently being taken:

I certify that the above information is accurate and complete and permit my treating physician to release any necessary medical information to Amtrak's Health Services Office. I have informed my treating physician of my current job responsibilities and have presented him/her with the Medication Reference Card.

Employee's Signature: _____ Date: _____

Physician: Complete and sign the bottom portion of this form and transmit it to the Amtrak Health Services confidential fax at 215-349-4401.

I, _____ have prescribed the following medication(s):
(print physician's name)

Medical condition/diagnosis	Medication	Dosage	Treatment Period (from-to-date)

I have reviewed the employee's job description and discussed the effect(s) of the listed medication(s) on performing his/her job duties safely. Based on the above, I authorize the following:

Check only one:

- Employee **IS NOT** authorized to perform his/her duties while taking this medication.
 Employee **IS** authorized to perform his/her duties while taking this medication.

Physician's Signature: _____ Date: _____

Telephone No.: () - Fax No.: () -