

Safety-Sensitive Fit for Duty

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Confidential Fitness for Safety-Sensitive Duty Report by
Employee's Treating Physician Concerning Evaluation of
Impairing Effect Medications [FMCSA22]

Entity Name

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Safety Policy

(a) No driver shall report for duty or remain on duty requiring the performance of safety-sensitive functions when the driver uses any controlled substance, except when the use is pursuant to the instructions of a licensed medical practitioner, as defined in 49 CFR 382.107, who has advised the driver that the substance will not adversely affect the driver's ability to safely operate a commercial motor vehicle.

(b) ***Entity Name***, having actual knowledge that a driver has used a controlled substance, shall not permit the driver to perform or continue to perform a safety-sensitive function.

(c) ***Entity Name*** may require a driver to inform ***Entity Name*** of any therapeutic drug use.

Additionally, as an essential job duty, all Drivers must remain medically qualified to drive in accordance with the standards set forth in 49 CFR 391.41 Physical Qualifications for Drivers.

Reporting Form Requirement. An employee in a safety-sensitive position must receive authorization to work *prior to* reporting for duty when taking any impairing effect medication(s) which may cause drowsiness or which may otherwise impair the employee's ability to safely perform his/her job. To obtain such authorization, an employee in a safety-sensitive position should have his/her doctor complete and sign a **Confidential Fitness for Safety-Sensitive Duty Report by Employee's Treating Physician Concerning Evaluation of Impairing Effect Medications** form and submit the form directly to the person whose name and contact information is set forth below. It is the employee's primary responsibility, in consultation with their health care professionals, to determine what medications they are taking which may or may not raise a significant safety concern. Employees are also primarily responsible for providing their health care professionals with a copy of their job description.

If "Cleared to Work" by the employee's evaluating physician, the supervisor may authorize the employee to work while under the influence of the impairing effect medication. However, the Company retains the right to not authorize an employee to take impairing effect medication while on duty or to revoke any previous authorization, despite the submission of a completed authorization form, if the Company's Medical Review Office (MRO) so advises the Company that the medication raises a significant safety concern. The Company, in its discretion, may request the MRO to issue an independent decision as to whether an employee in a safety-sensitive position may perform safety-sensitive duties while under the influence of an impairing effect medication, which decision will be binding on the employee. In making such an independent determination, the MRO is not bound in any way by the opinion of the employee's personal physician and may require the employee to submit to a fitness for duty examination by a Company-selected and compensated physician to ensure that the impairing effect medication does not raise a significant safety concern.

If the MRO determines that an employee in a safety-sensitive position should not perform safety-sensitive functions while under the influence of the impairing effect medication, the employee may be suspended, required to take a leave of absence or comply with other appropriate action to reduce or eliminate significant safety concern. If an employee fails to obtain pre-authorization to take such impairing effect medication from his/her supervisor in accordance with the above procedure, the employee may be required to take a leave of absence or comply with other appropriate action as determined by the Company and will be subject to discipline for violation of this safety rule.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with GINA, 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.

Please respond via fax and/or direct any questions regarding form completion to:

DESIGNATED EMPLOYER REPRESENTATIVE (DER)

NAME: ***DER***
TITLE: ***DER Title***
ADDRESS: ***DER Address***
 DER City/State/Zip
PHONE: ***Phone***
E-MAIL: ***EMAIL***

Fax completed form to ***DER FAX***

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INSTRUCTIONS FOR EMPLOYEES IN SAFETY-SENSITIVE POSITIONS

Confidential Fitness for Duty Reports are required by *Entity Name*** for employees in Safety-Sensitive Positions. If you are disclosing the use of an impairing effect prescription or over the counter medication, complete "Employee" section of this form, have your doctor complete "Physician" section, and forward directly to ***Entity Name*** at *** DER Fax*** or scan and email to ***Email***.**

IMPAIRING EFFECT MEDICATIONS -- To Be Completed by Physician

Instruction to Evaluating Physician on Form Completion: The Employer has a Pre-Duty impairing effects medication disclosure policy applicable to safety-sensitive employees. If in your medical opinion the employee is cleared to safely perform their safety-sensitive duties without restriction while under the influence of the below prescribed or over the counter medication(s) please sign off below. If not, please so indicate along with your comments on the nature and duration of the safety-sensitive related job restriction(s).

Employee: _____ ID: _____ Location Assigned: _____

To *Entity Name***:**

I understand and acknowledge the following: (1) the above employee works in a safety-sensitive position who discharges duties so fraught with risks of injury to self or others, environmental injury and/or property damage that even a momentary lapse of attention can have disastrous consequences; (2) that it is an essential job function safety rule applicable to every employee working in a safety-sensitive classified position to be able to work in a constant state of alertness and in a safe manner; (3) I have reviewed the employee's essential job functions/job description; and (4) this report is in regards to the above safety-sensitive employee who is currently under my care and has been prescribed, or is taking, the following impairing effect substance(s):

(Physician's Initials): _____

Treating Physician's Opinion (Initial One): Employee is; _____ Cleared to Work; _____ Not Cleared to Work at this Time; or Cleared to Work with Restrictions (recommendations below)

Recommendations: _____

| | | | |
|-------------------------------------|------------------|-------------|------------------|
| _____ | _____ | _____ | _____ |
| Treating Physician (Printed) | Signature | Date | License # |

Street Address: _____ City, State, Zip: _____

Phone () _____ Fax () _____ Email: _____

TO BE COMPLETED BY EMPLOYEE

I understand that it is my obligation as a safety-sensitive employee to inform Company Pre-Duty of any impairing effect medications I am taking, or that I intend to take, for review and determination of my eligibility to perform safety-sensitive duties. Pursuant to the Health Insurance Portability and Accountability Act (HIPPA), I authorize my medical provider to confidentially release my medical records directly to the MRO for ***Entity Name***, and confer with ***MRO***. This authorization shall expire at the conclusion of my employment with the Company and I may withdrawal my authorization at any time by written notice.

| | |
|----------------------|---|
| _____ | _____ |
| Employee's Signature | Employee's Work Location and Supervisor |

| | |
|-------------------------|-------|
| _____ | _____ |
| Employee's Printed Name | Date |

FOR *Entity Name*** USE ONLY**

Date Received: _____ Received by: _____

Approved Not Approved MRO Referred

_____ Date:

Safety-Sensitive Fit for Duty

Toolkit Forms

Significant Safety Concern Medical Examiner Assignment **from DER**

Significant Safety Concern Medical Examiner Assignment from DER (DER to Medical Examiner)

To: ***Medical Examiner***
From: ***DER***
RE: Fitness for Duty Evaluation
Employee: ***Donor***
Date:

This is to confirm that you have agreed to perform on the above referenced DOT covered employee a DOT mode specific appropriate fitness for duty evaluation to perform their DOT regulated functions following his/her receipt of a significant safety concern letter from the MRO. You should also render your medical opinion on whether the employee is fit for duty to perform their essential job duties set forth in their job description. You should direct your bill for this appointment to our office for payment. If the Employee fails to show for the appointment, please call our office 15 minutes after the appointment time and confirm by fax with your note of such at the bottom of a copy of this letter.

Attached you find copies of the following:

- 1) Significant Safety Concern Notification to DOT Safety-Sensitive Employee from DER with a HIPAA Release
- 2) MRO Significant Safety Concern Notification to the DER
- 3) Employee's Job Description
- 4) The MRO did or did not confer with the treating physician during the five-day business pause period of 49 CFR Part 40.135
- 5) The employee should be supplying to you directly their own medical records to expedite your review.

In conducting your Fitness for Duty Evaluation, you may conduct a peer-to-peer review with the employee's prescribing and/or treating physician, and if this is a CDL Driver, you should conduct this as a **Standard DOT Medical Exam Physical**. Additionally, you may consult with our Consulting Medical Review Officer/Certified Medical Examiner/Occupational Physician who can be contacted at:

Consulting MRO

Please let me know if you need anything further as we wish to expedite this process as much as possible. Direct your report confidentially to my attention by transmitting it via ***MRO Fax***

Many thanks

DER

TITLE: ***DER Title***
ADDRESS: ***DER Address***
DER City/State/Zip
PHONE: ***Phone***
E-MAIL: ***EMAIL***
FAX: ***DER Fax***