Medication Disclosure Policy (HRP020)

Introduction

At [*Company Name*], the safety and well-being of our employees are of paramount importance.

This form was designed to gather information about any prescribed medication that may affect an employee's ability to perform their job safely and effectively.

The purpose of this declaration is not to invade privacy, but to ensure that we are aware of any potential risks or accommodations that may be necessary. All information provided will be kept confidential and will be used solely for the purpose of maintaining a safe and productive work environment.

Who Should Complete This Form?

Any employee, who takes prescribed medication which may impact their job performance, and in particular, any employee in a role that involves safety-sensitive tasks, should complete this form.

How Do I Complete and Submit This Form?

Before you fill out the form, make sure that you have read and understood the questions asked. If you are not sure, contact your line manager for assistance.

1. Fill in the form by answering all the questions in it. Make sure that you know the pharmaceutical name of the medication you are taking, as well as the condition for which it has been prescribed.

2. Sign and date the form. This shows your acknowledgement that the information you have provided is accurate.

3. Submit the completed form to [*HR Administrator/Manager*] via email on [*email address*] or drop it off at [*office location*]. Alternatively, you can scan and upload it to [*self-service job portal link*].

If you have any questions about this form or the process, please reach out to the HR Department.

Medication Impact Assessment Form

Full Name	
Employee ID	
Position	
Department	
Date	

Medication Declaration

I, the undersigned, hereby declare that I am currently taking or have been prescribed the following medication/s that may have an adverse impact on my ability to perform my assigned duties.

Medication Name (1)	
Prescribed By	
Dosage	
Known Side Effects	
Impact on Duties	

Medication Name (2)	
Prescribed By	
Dosage	
Known Side Effects	
Impact on Duties	

Medication Declaration

I confirm that the information provided is true and correct to the best of my knowledge. I accept that it is my responsibility to inform [*Company Name*] of any changes to my prescription that may affect my ability to carry out my assigned duties.

I also understand that the information which I have provided herewith will be kept confidential and will be used solely for the purpose of ensuring a safe and productive work environment, in compliance with the relevant laws and legislation in South Africa.

EMPLOYEE

Full Name _____

Date _____

Signature _____

HR REPRESENTATIVE

Full Name _____

Date _____

Signature _____