WORK RECOMMENDATION / PRESCRIPTION MEDICATIONS APPROVAL FORM

Employee Name: _____

DOB _____ **Date** _____ **Supervisor**_____

Rig _____ **Job Title** _____

Name of Prescription Medication:	**Dosage:**
_____	_____
_____	_____
_____	_____
_____	_____

Recommendation Concerning Working While Taking Prescription Medication:

_____

_____

Reviewed by:

_____ **Date:** _____

Trinity Medical Control Physician

The above recommendation has been explained and any questions have been answered. This recommendation applies only to work activities while taking the medication(s) listed above. The recommendation is based upon safety considerations. This is not a recommendation concerning using this medication or concerning the treatment plan established by the treating physician. The treating physician should be consulted for any questions or concerns regarding the medical condition and/or treatment plan.

_____ **Date:** _____

Signature of Employee

_____ **Date:** _____

Signature of Supervisor

Please review this recommendation, sign it and fax it to Trinity Medical Management L.L.C. (225) 769-4984. If there are questions, please call (225) 769-4983.