**Marathon Oil Company (MRO) MEDICATION REPORTING FORM**

**The purpose of this form is to assist in determining if you can safely perform your work duties.**

**INSTRUCTIONS:**

1) Please complete the following information regarding any prescription and/or non-prescription medication you are currently taking which may impair your judgment or performance or which adversely affects the normal function of your mental faculties or physical abilities.

2) Fax the completed form to the appropriate number below, attention Corporate Health Physician Assistant:

MRO: Health Services - Houston, fax 713-296-4677 or call Physician Assistant 713-296-3918

3) Do not give a copy of this completed form to your supervisor or local Human Resources group. The information on this form will be kept in a confidential medical file maintained by Health Services. Local Human Resources will be advised only of any work restrictions or safety concerns. If you have not received clearance by the beginning of your next shift, inform you local Human Resources Representative or your supervisor that a form has been sent to Health Services and that no response has yet been received.

4) If you are currently aware of limitations in your ability to safely perform the essential functions of your job due to your taking the medications listed, DO advise your supervisor immediately of the limitations.

Employee Name: Employee No.:

Next Scheduled Shift: Date: Time: Work Phone: Hours:

Work Location: Job Title: Home Phone: Hours:

Supervisor: Location: Work Phone:

Medication: Dosage (i.e., 500mg):

Administration (i.e., 1 tsp. 3 x/day; 1 tablet at bedtime):

Start Date:  Duration (i.e., 14 days):

Precautions (i.e., Dizziness - no stairs climbing):

Physician’s Name & Number: ( )

Medication: Dosage (i.e., 500mg):

Administration (i.e., 1 tsp. 3 x/day; 1 tablet at bedtime):

Start Date: Duration (i.e., 14 days):

Precautions (i.e., Dizziness - no stairs climbing):

Physician’s Name & Number: ( )

Medication: Dosage (i.e., 500mg):

Administration (i.e., 1 tsp. 3 x/day; 1 tablet at bedtime):

Start Date: Duration (i.e., 14 days):

Precautions (i.e., Dizziness - no stairs climbing):

Physician’s Name & Number: ( )

Signature:  Date:

**THIS FORM IS TO BE USED ONLY BY MRO EMPLOYEES. CONTRACT EMPLOYEES SHOULD NOTIFY THEIR RESPECTIVE COMPANY FOR EVALUATION.**