



Cobb County...Expect the Best!

DRUG NOTIFICATION FORM

(To be used for employees holding safety sensitive positions, CDL positions, or who regularly drive a county vehicle.)

Name of Employee: _____

Job Title: _____

1. I am taking a prescribed drug or substance which carries a warning label that indicates that mental functioning, motor skills, and/or judgment may be adversely affected or to use caution when operating machinery or motor vehicles.

- Yes
 No

2. I am taking an over the counter medication in excess of the recommended dosage instructions.

- Yes
 No

If you checked “yes” to Question 1 or 2, you will need to speak to your prescribing physician and complete the following information below.

3. I have discussed the essential functions of my position with the prescribing physician and he/she has cleared me to use this medication.

- Yes
 No

4. I agree to only use the medication as directed by the prescribing physician.

- Yes
 No

5. Please list any restrictions that the physician has placed you on while using the medication.

I further certify that the information contained on this form is true and correct. I understand that under the Drug Free Workplace Policy, I am not permitted to report for duty or remain on duty if I have used any prescription or over the counter medication, except where the use is in strict accordance with the recommended dosage instructions of a licensed medical practitioner who has advised me that the substance will not adversely affect my ability to safely perform the duties of my position.

Employee Signature: _____ Date: _____

This form must be completed every time you start taking medication or make any modifications to current medications that you would check “yes” to Question 1 or 2. Failure to complete this form and turn it into your supervisor may result in disciplinary action.

