Medication Approval Form
Western Community Action

Driver Section:

Printed Name: ____

Person named above: (please check all that apply)

_____ is a driver for Community Transit

_____operates a transit bus for Community Transit

Prescription/over-the-counter medication currently being taken (if not currently on medication, please note N/A on line):

____

____

I attest that the foregoing information is complete and correct.

Driver Signature__________________________________ Date_______________________

Physician's/Pharmacist's Section:

As the attending physician or pharmacist, I have advised the driver listed above about the usage of the following prescription/over-the-counter medication:

Medication	Dosage	Date or Duration of Prescription
__________________________	______________	from_________ to __________
__________________________	______________	from_________ to __________
__________________________	______________	from_________ to __________

As the attending physician or pharmacist, I recommend that this person:
_______should not drive while taking by this medication
_______ may drive while taking this medication.

Comments: ____

____ Physician's/Pharmacist's Printed Name

_________________________ Telephone Number

____ Physician's/Pharmacist's Signature

_________________________ Date

Supervisory Signature: _______________________________Date: __________________

Human Resource Director Signature: _______________________________Date: __________________