CLEARANCE TO WORK

I AUTHORIZE MY HEALTH CARE PROVIDER_____ TO RELEASE MEDICAL INFORMATION TO **(inset name of company)**; WHICH IS RELATED TO **SAFETY SENSITIVE EMPLOYMENT CRITERIA, WHILE EMPLOYED IN CLASS A HEAVY INDUSTRY ASSIGNMENT(S).**

NATURE OF MEDICATION:

_____

EMPLOYEE NAME: _____ PROJECT: _____

EMPLOYEE SIGNATURE: _____ DATE: _____

HEALTH CARE PROVIDER, In determining whether a worker's use of a Medication may reasonably be considered as having the potential to impair cognitive function, concentration, coordination and/or motor functions while working;

PLEASE COMPLETE THE FOLLOWING:

Is employee able to perform full work duties as per his job demands? YES ___ NO ____

If not what restrictions are applicable? PLEASE CIRCLE LIMITATIONS/RESTRICTIONS

OPERATION OF:	**ACCESSING WORKSITE:**	**MOBILITY:**
ELEVATING EQUIPMENT	**CLIMBING SCAFFOLD**	**LIFTING / CARRYING (Weight): _____**
MOTOR VEHICLES	**USE OF EVELVATING PLATFORMS**	**WALKING FLAT**
MOBILE EQUIPMENT	**WORKING AT HEIGHTS**	**WALKING UNEVEN**
NOISE	**RESPIRATOR USE**	**CONFINED SPACE**
DETAIL WORK (requiring cognitive skills)		

ANY ADDITIONAL COMMENTS that will assist us in ensuring the worker and others are not at risk:

_____

_____

_____

Please invoice **(insert name of company)** for costs associated with completing this form. We will pay as per the BCMA fee code.

_____ _____ _____

Health Care Provider's Name (Please print) | Address | Phone No.

_____ _____

Signature of Health Care Provider | Date