

Form Number LLCF-021	Issue Date 10/25/11	Revision Date 06/15/23	Form Number LLCF-021
	Statement of Employee Medications		

Not Required – To be filled out voluntarily by employee.

JOB DESCRIPTION: _____	SUPERVISOR: _____
EMPLOYEE NAME: _____	EMPLOYEE DOB: _____

TODAY'S DATE: _____	ONSHORE	OFFSHORE
DEPARTMENT: _____		

PLEASE LIST ANY MEDICATION(S) THAT MAY BE SAFETY SENSITIVE:

	MEDICATION NAME	DOSAGE	TAKEN AT WORK?	
			YES	NO
1)	_____	_____	YES	NO
2)	_____	_____	YES	NO
3)	_____	_____	YES	NO
4)	_____	_____	YES	NO
5)	_____	_____	YES	NO
6)	_____	_____	YES	NO
7)	_____	_____	YES	NO
8)	_____	_____	YES	NO
9)	_____	_____	YES	NO

_____	_____
EMPLOYEE SIGNATURE	EMPLOYEE PRINT