Form Number LLCF-021	Issue Date 10/25/11	Revision Date 01/15/25	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 SENSETIVE:

	MEDICATION NAME	DOSAGE	TAKEN AT WORK?	
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