

Form Number LLCF-021	Issue Date 10/25/11	Revision Date 01/15/26	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/GIS Company Name: _____	

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

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

_____	_____
EMPLOYEE SIGNATURE	EMPLOYEE PRINT