

**Authorization to Perform
Department of Transportation Safety-Sensitive Duties
While Using a Controlled Substance**

To be completed by the employee -

I, _____ authorize the release of the following information by my prescribing physician to West Virginia University's DOT Designated Employer Representative in the Talent and Culture, Medical Management Office for retention in my confidential DOT Drug and Alcohol Testing file.

Signature

Date

To be completed by the prescribing physician -

My patient is employed with West Virginia University. As an employee working in a safety-sensitive position, he/she is required to provide the following authorization, prior to resuming his/her position while using the following medication(s).

- AUTHORIZATION -

I understand that _____ is a WVU employee working in a DOT Safety-Sensitive position.

For medical purposes, I have prescribed the following medication(s):

- _____
- I am not aware of any other medications (prescription or over-the-counter) for this employee
 - In addition to this medication, this employee also takes the following: _____

It is my determination that the above-mentioned employee may safely perform his/her required DOT Safety-Sensitive duties while using the medication(s) named above.

Licensed Medical Practitioner (Printed Name)

(Signature)

Phone

Fax

Date