

# Over the Counter and Prescription Drug Policy

*Contracting Agency Name*  
*Transit System Name*

Accepted Date: \_\_\_\_\_

Revised: \_\_\_\_\_

Revised: \_\_\_\_\_

Revised: \_\_\_\_\_

**TRANSIT SYSTEM NAME** is dedicated to providing safe, dependable and efficient transportation services to its passengers and a safe and productive work environment for its employees. To ensure delivery of this service, each **TRANSIT SYSTEM NAME** employee has the responsibility to perform his/her duties in a safe, conscientious, and courteous manner. This Over-the-Counter/Prescription (OTC/Rx) policy lists and describes the provisions set forth under the **TRANSIT SYSTEM NAME's** own authority. All safety sensitive employees must notify **TRANSIT SYSTEM NAME** of the *use* of Prescription (Rx) and Over-The-Counter (OTC) Medications. This policy applies to all safety sensitive employees and should be considered a separate policy from Oklahoma Consortium Drug and Alcohol Testing Program Policy. These guidelines have been established to help ensure the safety of our passengers, employees, and drivers.

## 1. Program Statement

Covered employees will be responsible for discussing medications with their prescribing physician to determine whether or not they can safely perform their job duties while taking one or a combination of medications. Prescription and over-the-counter medications can significantly affect the performance of people taking them. Many such medications can make the patient drowsy or dizzy, affect vision or hearing, or bring about other physical conditions that could reduce the effectiveness of a safety sensitive employee. An employee is permitted to use such medications, as determined by a physician or treating medical practitioner, if the use of the substance by the employee at the prescribed or authorized dosage level is consistent with the safe performance of the employee's duties. Employees in safety sensitive positions are

required to notify their supervisor and/or **DER** of all Rx and OTC medications that carry a warning label advising against driving a motor vehicle or operating machinery while taking this medications, and/or other health warnings or contraindications by completing and submitting a *Safety Sensitive Employee Medication Approval Form for Prescription Medications (Attachment 1)* and/or a *Safety Sensitive Employee Medication Form for Over-The-Counter Medications (Attachment 2)* so that, if needed, **TRANSIT SYSTEM NAME** can allow qualified medical personnel to determine the medication's potential effects on employee performance. Failure to notify the supervisor and/or **DER** of all Prescription and Over-The-Counter medications carrying a warning label advising against driving a motor vehicle or operating machinery while taking this medications, and/or other health warnings or contraindications will result in discipline, up to and including discharge.

## 2. Purpose

This policy applies to all safety sensitive employees who are employed by, or who are assigned to work for, **TRANSIT SYSTEM NAME**. It defines the safety sensitive employee's responsibility clearly for both Rx and OTC medications. It lists prohibited behaviors and discipline for policy violations.

## 3. Definitions

### *3.1 Designated Employer Representative (DER) (§40.3)*

An employee authorized by the **TRANSIT SYSTEM NAME** to take immediate action(s) to remove employees from safety-sensitive and to make required decisions in the testing and evaluation processes. The DER also receives test results and other communications for **TRANSIT SYSTEM NAME**, consistent with the requirements of this part. Service agents cannot act as DERs.

### *3.2 Prescribing Physician*

Any medical practitioner who is allowed to prescribe medication. Includes physicians, pharmacists, psychiatrists, dentists, physician assistants, etc.

### *3.3 Legally Prescribed Drug*

Prescription Drugs (Rx) are medications, which require written authorization for use by a healthcare professional whose license permits them to prescribe medication. The prescription must include the patient's name, the name of the substance, quantity/amount to be dispensed, and instructions on frequency and method of administration, refills, and date. For the purpose of this policy, a legally prescribed drug is one that is documented on *The Safety Sensitive Employee Medication Approval Form For Prescription Medications, (Attachment 1)* by a prescribing physician. The prescription bottle alone is not sufficient to meet the requirements of this policy.

### *3.4 Over-The-Counter Medications*

Over-The-Counter (OTC) Medications are any legal, non-prescription substance taken for relief of discomforting symptoms. May include capsules, gel caps, powders, tablets or liquids.

### *3.5 Safety-Sensitive Functions (§655.4)*

A safety-sensitive function is any duty related to the safe operation of mass transit service. These duties include, but are not limited to, the following activities:

- Operating a revenue service vehicle, including when not in revenue service;
- Operating a non-revenue service vehicle, when required to be operated by a holder of a Commercial Driver's License (CDL);

- Controlling dispatch or movement of a revenue service vehicle;
- Performing maintenance functions including repairing, overhauling, and rebuilding revenue service vehicles or equipment used in revenue service;
- Providing security and carrying a firearm on transit vehicles, at transfer points, and in transit facilities open to the public.

#### 4. Prohibited Behaviors

4.1 Using a Prescription (Rx) medication that is not legally prescribed for the employee.

4.2 Using an Rx or Over-The-Counter (OTC) medication in excess of the prescribed dosage.

4.3 Using any medication that contains alcohol within four (4) hours before performing safety-sensitive functions.

4.4 Using any medication that adversely impacts the employee's ability to safely perform his/her safety sensitive job functions.

#### 5. Reporting of Prescribed Drugs

In the interest of protecting employees and others, safety sensitive employees must make sure that any prescribed drug or any combinations of drugs being taken will not adversely impact their job performance. The prescribing physician must approve the medications to ensure that the employee's job duties can be performed safely. This approval must be reported in writing to **TRANSIT SYSTEM NAME** via The Safety Sensitive Employee Medication Approval Form for Prescription Medications.

(Attachment 1) Additional copies may be obtained from your supervisor and/or ***DER of TRANSIT SYSTEM NAME.***

5.1 The employee is responsible for providing the prescribing physician with *The Safety Sensitive Medication Approval Form for Prescription Medications.* (Attachment 1). The “Employee’s Section” is to be completed before giving the form to the physician. Additionally, the employee shall directly advise the physician if he/she operates a vehicle or performs other safety sensitive duties.

5.2 The employee is responsible for discussing the potential effects of any prescription medication with the prescribing physician, including its potential to impair mental functioning, motor skills or judgment, as well as any adverse impact on the safe performance of his/her safety sensitive job duties.

5.3 The employee is encouraged to ask his/her physician for alternative treatments that do not have performance altering side effects.

5.4 An employee will be medically disqualified from the performance of safety sensitive functions if the prescribing physician determines that the employee’s medical history, current condition, side effects of the medication being prescribed and other indications pose a potential threat to the safety of co-workers, the public and/or the employee.

5.5 Ultimately, the employee may be the best judge of how a substance is impacting him/her. As such, the employee has the responsibility to inform the prescribing

physician of performance altering side effects and request medical disqualification from performance of safety sensitive duties. (Employees on duty should immediately contact their supervisors and/or **DER** for relief from safety sensitive work.)

## 6. Reporting of Over-The-Counter (OTC) Medication

It is the responsibility of safety sensitive employees when selecting an OTC medication to read all warning labels before selecting it for use while in working status.

6.1 Medications whose labels indicate they may affect mental functioning, motor skills, judgment, or carrying a warning label advising against driving a motor vehicle, operating machinery, or other health warning or contraindications should not be selected.

6.2 If no alternate medication is available for the condition, employees should seek professional assistance from their physician.

6.2.1 The physician may determine that OTC medication with potentially negative impact is the preferred choice for treatment and can use The Safety Sensitive Employee Medication Approval Form for Prescription Medications (Attachment 1) to withhold the employee from work. Employees are to convey this information immediately to their supervisor and/or **DER** to explain their absence.

6.3 Ultimately, the employee may be the best judge of how a substance is impacting him/her. As such, the employee has the responsibility to refrain from using any OTC medication that causes performance-altering side

effects, whether or not the label warns of them. The at-work employee is to contact his/her supervisor and/or **DER** for relief from safety sensitive duties and seek the assistance of his/her physician in selecting an alternative treatment.

## 7. Fitness for Duty

Employees have the personal responsibility to assess their fitness for duty while using Rx or OTC medication. They should not report for, or remain on duty while being adversely affected by a prescription medicine even if they have the Safety Sensitive Employee Medication Approval Form for Prescription Medications (Attachment 1) that releases them to work or if the OTC medication being taken has no warning label.

## 8. Discipline

8.1 A safety sensitive employee who violates this policy is to be removed from service immediately.

8.2 Violation of this policy will subject an employee to disciplinary action up to and including termination of employment.

8.3 Once removed from service under 8.1 above, an employee may not be returned to safety sensitive duties until evaluated and released by a physician. The cost for this service shall be the responsibility of the employee.

## **Attachment 1:**

## **Safety Sensitive Employee Medication Approval Form for Prescription Medications**

Employee's Section:

Printed Name \_\_\_\_\_

Employee's Safety Sensitive Job Function – Check those that apply.

- Operate a transit vehicle
- Control the dispatch or movement of a transit vehicle
- Maintain/repair transit vehicles

Medication(s) currently being taken:

I attest that the foregoing information is complete and accurate.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

Physician's Section:

As the attending physician, I have prescribed the following

medication(s) to be taken from \_\_\_\_\_ to \_\_\_\_\_.

\_\_\_\_\_  
Name of Medication

\_\_\_\_\_  
Dosage

\_\_\_\_\_  
Name of Medication

\_\_\_\_\_  
Dosage

Please Check One Of The Following:

\_\_\_\_\_ Employee **may not perform safety sensitive duties** while taking this medication.

\_\_\_\_\_ Employee is **released** to perform safety sensitive duties while taking this medication.

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Telephone No.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Attachment 2:**

## **Safety Sensitive Employee Medication Form For Over-The-Counter Medications**

Employee's Section:

I, \_\_\_\_\_, am a Safety Sensitive employee  
Print/Type Name Legibly

of ***TRANSIT SYSTEM NAME.***

My job title is \_\_\_\_\_,  
Print/Type Job Title

And my work location is \_\_\_\_\_.  
Print/Type Work Location

I take the following over-the-counter medications carrying a warning label advising against driving a motor vehicle or operating machinery while taking this medications, and/or other health warnings or contraindications as directed\* on the package as needed.

**PLEASE ATTACH A COPY OF EACH LABEL FOR MEDICATIONS LISTED.**

**\* If the medication is not taken as directed, please explain:**

**GENERAL PAIN RELIEF**

**COLD/FLU MEDICATION**

**SINUS RELIEF**

**VITAMINS/MINERALS/HERBS**

**OTHER**

**OTHER**

I understand that it is my obligation to inform ***TRANSIT SYSTEM NAME*** of any medication I intend to take carrying a warning label advising against driving a motor vehicle or operating machinery while taking this medications, and/or other health warnings or contraindications for review and determination of my eligibility to work.

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Employee's Signature

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Date

***Attachment 3:***

**Post-Accident Drug & Alcohol Testing  
Decision Documentation Form**

***Refer To: TRANSIT SYSTEM NAME Drug and Alcohol Testing  
Program Policy, Section 5.4***

**TRANSIT SYSTEM NAME Drug and Alcohol Testing Program Policy** and the Federal Transit Administration (FTA) drug and alcohol testing regulation (49 CFR Part 655) require that employees involved in a vehicle accident (as defined in the Policy) submit to tests for alcohol and prohibited drugs as soon as possible following the accident. The policy also requires the testing of any other safety-sensitive employee whose performance could have contributed to the accident, as determined by the supervisor at the scene using the best information available at the time of the decision.

This Rx/OTC form should be completed anytime the initial accident investigation indicates that Prescription or OTC drugs could be a contributing factor to the accident. The information obtained should be kept confidential.

Do not ask the employee the “reason” they were/are taking a specific drug. However, if the employee volunteers information, this information should be noted.

***Accident Information:***

Date of Accident \_\_\_\_\_ Time of Accident: \_\_\_\_\_ am \_\_\_\_\_ pm

Employee Name \_\_\_\_\_

***Decision Questions:***

Was there a human fatality? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, Post-Accident tests are required.

If there was no fatality, ask the following questions:

1. Has any individual suffered a bodily injury and immediately received medical treatment away from the scene of the accident?

Yes\_\_No\_\_

2. Was there a disabling damage to the company vehicle or any other vehicle as a result of the occurrence and the vehicle was transported away from the scene by a tow truck or other vehicle?

Yes\_\_No\_\_\_\_\_

Disabling Damage Definition (§655.4): Damage, which precludes departure of any vehicle from the scene of the occurrence in its usual manner in daylight after simple repairs. Disabling damage includes damage to vehicles that could have been operated but would have been further damaged if so operated, but does not include damage which can be remedied temporarily at the scene of the occurrence without special tools or parts, tire disablement, without damage even if no spare tire is available, or damage to headlights, taillights, turn signals, horn, mirrors, or windshield wipers that makes them inoperative.

3. Was the vehicle removed from operation? Yes\_\_\_\_\_ No\_\_\_\_\_

If you checked YES to questions 1,2 or 3 above, a Post-Accident test is required under DOT/FTA rules unless you determine, using the best information available at the time of the decision, that the employee's performance can be completely discounted as a contributing factor to the accident. *(Any reason for NOT conducting a Post-Accident test after you've answered YES to any of the above questions **MUST BE DOCUMENTED.***

Employee was taken to \_\_\_\_\_  
(Name of Collection Site)

By \_\_\_\_\_ Title \_\_\_\_\_ at \_\_\_\_\_ am \_\_\_\_\_ pm

Employee was not tested \_\_\_\_\_ (See documentation)

FTA regulations also require that alcohol testing must be done as soon as possible following the accident. If alcohol testing is not conducted within 2 hours after the accident, you must document the reason of the delay. If the alcohol test is not administered within 8 hours, you must cease all

efforts to administer the test and document the reason(s) for failure to test. Drug tests must be administered within 32 hours of the accident.

**Time Test Requirement:**

If the employee was NOT tested, please check/fill in information below:

Employee left scene of accident after being told to stay (refusal to test)

Yes\_\_\_\_No\_\_\_\_\_

If yes, explain below:

Employee refused outright to take test

Yes\_\_\_\_\_No\_\_\_\_\_

If yes, inform employee this is considered a positive test and explain below:

Employee unavailable through no fault of his/her own (Example:  
Employee is unconscious or unable to give consent for various reasons.)

Yes\_\_\_\_\_No\_\_\_\_\_

If yes, explain below:

Did the employee indicate recent use of Prescription or Over-The-Counter medications?

Yes \_\_\_\_\_ No \_\_\_\_\_

*Employees in safety sensitive positions are required to have submitted The Safety Sensitive Employee Medication Approval Form for Prescription Medications (Attachment 1) and/or The Medication Form for Over-The-Counter Medications (Attachment 2) for all medications that carry a warning label advising against driving a motor vehicle or operating machinery while taking this medications, and/or other health warnings or contraindications. The employer will relay this information to qualified medical personnel to determine the medication's potential effects on employee performance. Failure to provide proper notification will result in discipline, up to and including discharge.*

Is employee taking any Prescriptions and /or Over-The-Counter Medications?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, complete *Medication Information Form* (Attachment 3) for each medication.

Did employee follow the procedures as required by **TRANSIT SYSTEM NAME** Over-The-Counter and Prescription Drug Policy?

Yes \_\_\_\_\_ No \_\_\_\_\_

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Signature of Decision Maker

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Title

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Date

***Attachment 4:***

**Medication Information Form**

**CONFIDENTIAL**

1. Name of Medication:
2. How much do you take (dosage)?
3. How often do you take it (frequency)?
4. How long have you been taking this medication?
5. For prescription medications, is the prescription in your name?
6. When was the last time you took a dose?

How much did you take?

7. Did you take a dose prior to the last one?

How much did you take?

8. How many times have you taken it in the last 7 days?
9. Did you experience any side effects? If so, describe:

When did the side effects first appear?

When did the side effects disappear?

10. Have you discussed the use and potential side effects of this Prescription/OTC medication with your physician?

If yes, when?

Is the physician aware of your safety-sensitive job duties?

Describe:

11. Have you discussed the use of this Prescription/OTC medication with your pharmacist?

If yes, who?

When?

Is the pharmacist aware of your safety-sensitive job duties?

Describe:

**CONFIDENTIAL**

Do you have the medication with you? If yes, write down the information from the label.

If no, provide the following information:

Name of Medication:

Expiration Date:

Dosage Information (exactly):

Note any warning labels:

Form:	Pill	Capsule	Gel cap
	Liquid	Other	

Place of Purchase:

Pharmacist Name (if applicable):

Pharmacist Phone Number: