Fitness for Duty Verification

(Company name, address, contact name & phone #)

TO THE MEDICAL PROVIDER

This company is tasked with providing a safe and healthful work environment and to protect our customers and public citizens. Because of HIPPA and other personal privacy requirements, we ask that you please complete the following information so that our employee's privacy rights are protected.

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*This is to verify that (print employee name)*_____

*has been seen by this office on (date)*_____. *I understand that the company and employee listed above must comply with U.S. DOT Federal Motor Carrier Administration Safety Regulations, specifically part 391.41. I further verify that the employee listed above is under prescription and/or non-prescription medications that will* ***not*** *adversely affect his/her ability to safely operate commercial motor vehicles, forklift trucks, and other equipment.*

*DOCTOR/CLINIC:*_____

*ADDRESS:*_____

*PHONE:*_____

*CONTACT NAME:*_____

*DIRECT PHONE #:*_____