Partners In Safety

___ 800 Route 17M, Middletown, NY 10940 845-341-0515(P) 845-341-0710(F)

___ 15 North Broadway, Ste. D, White Plains, NY 10601 914-285-0434(P) 914-288-9516(F)

___ 55 Old Nyack Tpke., Ste 401, Nanuet, NY 10954 845-624-3882(P) 845-624-3992(F)

___ 408 West 45th Street, New York, NY 10036 212-727-8637(P) 212-246-0269(F)

Medication Clearance Letter

Your patient is being evaluated for fitness to drive a commercial motor vehicle. Please provide the following information regarding a medication for which the patient has indicated he/she has a prescription. Please review and sign the opinion statement at the end with comments. Your assistance is greatly appreciated.

Patient Name ____

Company Name ____

Medication ____

Indication for treatment ____

Dose _______________ **Frequency** _____________ **# of pills prescribed per month** ____________

How frequently used if ordered as needed ____

Taken during work hours: **yes** **no**

PLEASE ATTACH A PRINTOUT OF ALL CONTROLLED SUBSTANCES PRESCRIBED, EITHER FROM NYS PMP REGISTRY OR ELECTRONIC HEALTH RECORD.

Comments ____

I certify that, in my professional judgment, this medication will not affect his/her ability to safely operate a commercial motor vehicle.

Physician's Stamp- phone #

____
Physician's Signature

____
Physician's Printed Name/License No.

____
Date