TERMINAL RAILROAD ASSOCIATION OF ST. LOUIS
SWITCHMAN
PRESCRIPTION AND/OR OVER-THE-COUNTER MEDICATION WORK AUTHORIZATION FORM

The bearer of this letter, _____, an employee of the TERMINAL RAILROAD ASSOCIATION OF ST. LOUIS, may be required to perform one or more of the following in the performance of his/her duties as a Switchman: Receive verbal instructions pertaining to the movement of trains and equipment; read, understand, memorize and communicate written and verbal instructions; lift and carry 20-90 lbs.; push and pull 25-120 lbs.; climbing on and off locomotive using ladder; operate remote control locomotive; maintain balance while walking on uneven surfaces/ballast; bending, stretching, standing, stooping, pushing, and pulling for an extended period of time.

This employee is a regulated service employee governed by Code of Federal Regulation Part 219, drug and alcohol usage in the workplace.

Our rules require (in part): Employees must not report for duty or be on Company property under the influence of, or use while on duty, any over-the-counter or prescription drug or medication which will in any way adversely affect their alertness, coordination, reaction, response, or safety. If an employee is taking an over-the-counter or prescription drug that may have an adverse effect on their alertness, coordination, reaction, response, or safety, the employee should make sure that the following step is taken:

> A **physician** or **dentist** licensed or otherwise authorized to practice by a state of the United States or a physician designated by the Railroad makes a good faith judgment, in writing, with notice of the employee's assigned duties and on the basis of the available medical history, that use of the substance by the employee at the prescribed or authorized dosage applicable is consistent with the safe performance of the employee's duties.

SECTION I - PRESCRIBING PHYSICIAN'S STATEMENT: (Please print or type Medication/Dosage below)
****For more than two medications complete a second form**

Medication	**Dosage/Administration**

Prescribing Physician's Comments:

_____

_____

The above prescribed dosage should not have an adverse effect, and based on the available medical history, the prescribed medication taken at the authorized dosage is consistent with the safe performance of _____.

Prescribing Physician's Name: _____ **Signature:** _____
(Please print or type)

Date: _____

SECTION II - ACKNOWLEDGMENT OF EMPLOYEE:

I understand the above medication must not be taken in excess of the prescribed dosage. This authorization must be on file with the Company prior to any use in accordance with GCOR 1.5.

Employee Signature: _____ **Date:** _____

Employee Contact Number: _____

SECTION III - COMPANY PHYSICIAN'S COMMENTS:

_____

_____

The above prescribed dosage should not have an adverse effect, and based on the available medical history, the prescribed medication taken at the authorized dosage is consistent with the safe performance of Switchman employee.

_____: This is your authorization to work as a Switchman employee while taking the above medication at the prescribed dosages. However, this does not relieve you of your responsibility of not being on duty or on Company property should this medication cause any undue side effects or adversely affect your alertness, coordination, reaction or safety.

Company Physician's Name: _____ **Signature:** _____
(Please print or type)

Date: _____

- Section I is to be completed by the employee's physician.
- Section II is to be completed by the employee.
- Once Sections I & II are completed, please email this form to Gateway Occupational Health at daniel.stephens@amhealthsystems.com or fax this form to 618-798-3868.
- Contact Gateway Occupational Health at 618-798-3475 to verify receipt of prescription form or with any questions.

*DO NOT RETURN THIS FORM TO YOUR MANAGER.