

APPENDIX A MEDICAL USE OF AN IMPAIRING SUBSTANCE REPORT FORM

| Date: | | | | |
|---|--|--|--|--|
| Employee Name: | | | | |
| SECTION A: To be completed by Loyalist College: | | | | |
| Is this individual in a safety-sensitive position? [] No [] Yes (if Yes, please identify safety-sensitive tax | sks below) [] Working with high voltage [] Administering medications [] Operating medical equipment [] Responsible for safety/wellbeing of others [] OTHER: Please describe | | | |
| SECTION B: To be completed by employee: | | | | |
| I hereby authorize my care provider,, to complete this report and return to Lisa Lynn – Human Resources Services. | | | | |
| Employee Signature | Date: | | | |

SECTION C: To be completed by Attending Physician:

As part of our commitment to Health and Wellness, Loyalist College is focused on proactively creating a culture of wellness for the betterment of students, staff and faculty. The above-named individual is seeking special provisions because they recognize that their medication affects their ability to work. Please note that as of January 1, 2019, smoking is prohibited on College property. If medical cannabis is being prescribed, Loyalist College encourages alternative methods of administration.

In our efforts to make appropriate arrangements that considers the safety of this employee and others on the campus, please complete the following information:

| 1. | | | | | | |
|----------------|----------------------------|--|--|--------------------|--|--|
| W | /hat is the substance? | | | | | |
| W | /hat is the strength/dosa | ge? | | | | |
| | /hat is the frequency of (| | | | | |
| W | /hat is the method of ad | ministration (i.e. oral, | | | | |
| to | pical, smoked, or inhala | tion)? | | | | |
| | | · | | | | |
| | | her therapies as an altern arrangement will this indi | ative to this substance? vidual require? | []Y []N | | |
| - - 4 | Please identify the pote | ntial cognitive effects on f | | | | |
| | | Low/no impact | Moderate impact | Significant impact | | |
| | lertness | | | | | |
| - | rientation | | | | | |
| A | ttention/Concentration | | | | | |
| N | lemory | | | | | |
| Jι | ıdgment | | | | | |
| N | lood | | | | | |
| Fá | atigue | | | | | |
| P: | sychomotor function | | | | | |
| 6. I | above? [] Yes [] N | o nnabis, please attach a ph | ne safety-sensitive tasks id notocopy of the prescription question is not medical ca | on. | | |
| 7. I - - | Please identify any furth | er restrictions required fo | r this employee: | | | |
| | · | | | | | |
| 9. \ | When is your next follow | -up visit with this patient | ? | | | |
| | Attending Physician N | ame | Signature | Date | | |

Thank you for completing this form. Should you have any questions or require further information, please feel free to contact me at 613-969-1913 ext. 2418.