Date: [Insert Date]

To: [Medical Professional Name/Occupational Health Department]
From: [Employer Name/Manager Name]
Subject: Fitness to Work Prescription Side Effect Evaluation

Employee Name: [Insert Employee Name]
Job Title: [Insert Job Title]

Dear [Medical Professional Name],

The above-named employee is currently performing duties that involve [List safety-sensitive tasks, e.g., operating heavy machinery, driving, or high-level decision making].

The employee has disclosed that they are currently taking prescribed medication. We are requesting a formal evaluation to determine if any side effects of this medication may impair their ability to perform these specific tasks safely. Specifically, please address the following:

- Does the medication cause drowsiness, dizziness, or reduced motor coordination?
- Is the employee's cognitive function, concentration, or reaction time affected?
- Are there specific restrictions required (e.g., no driving, modified hours)?
- What is the expected duration of these side effects/restrictions?

Please note that we are not requesting the name of the medication or the underlying medical diagnosis, only an assessment of the employee's functional capacity and safety in the workplace.

A copy of the employee's job description is attached for your reference. A signed authorization for the release of this information is also enclosed.

Thank you for your assistance in ensuring a safe working environment.

Sincerely,

[Signature]
[Print Name]
[Title]
[Company Name]