Marathon Oil Company MEDICATION REPORTING FORM

Employees are required to submit this form, when applicable, using the instructions below. The purpose of this form is to assist in determining if you can safely perform your work duties.

THIS FORM IS TO BE USED ONLY BY MRO EMPLOYEES. CONTRACT EMPLOYEES SHOULD NOTIFY THEIR RESPECTIVE COMPANY FOR EVALUATION.

INSTRUCTIONS:

1) Complete the following information regarding any prescription and/or non-prescription medication you are currently taking which may impair your judgment or performance or which adversely affects the normal function of your mental faculties or physical abilities. **If you question your obligation to report a certain medication, it's best to report. Safety first!**

- Examples of when a Medication Reporting Form should be submitted (these are not all inclusive):
  - Side effects of the medication may include drowsiness, impaired vision, dizziness, etc.
  - Medication is not recommended while driving or operating heavy machinery.
  - You believe the medication may limit your ability to perform your normal job duties.
  - Medications containing opiates, benzodiazepines, barbiturates, amphetamines (painkillers, sedatives & sleeping pills (if taken with 6 hours of duty), seizure medications, anti-anxiety drugs, attention deficit disorder drugs – anything with a warning on the bottle!)

2) Email the completed form to Corporate Health Resources (CHR) at marathonoil@chr.com. Phone number is 1-800-867-0933. If CHR determines there are work restrictions, you will be contacted by Marathon's medical consultant.

3) Do not give a copy of this completed form to your supervisor or local Human Resources group. The information on this form will be kept in a confidential medical file maintained by CHR. Human Resources will be advised only of any work restrictions or safety concerns. If you have not received clearance by the beginning of your next shift, inform your local Human Resources Representative or your supervisor that a form has been sent to CHR and that no response has yet been received.

4) If you are currently aware of limitations in your ability to safely perform the essential functions of your job due to your taking the medications listed, DO advise your supervisor immediately of the limitations.

Employee Name: _____ Employee No.: _____
Next Scheduled Shift: _____ Date: _____ Time: _____ Work Phone: _____ Hours: _____
Work Location: _____ Job Title: _____ Home Phone: _____ Hours: _____
Supervisor: _____ Location: _____ Work Phone: _____

Medication: _____ Dosage (i.e., 500mg): _____
Administration (i.e., 1 tsp. 3 x/day; 1 tablet at bedtime): _____
Start Date: _____ Duration (i.e., 14 days): _____
Precautions (i.e., Dizziness - no stairs climbing): _____
_____
Physician's Name & Number: _____ (____) _____

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Administration (i.e., 1 tsp. 3 x/day; 1 tablet at bedtime): _____
Start Date: _____ Duration (i.e., 14 days): _____
Precautions (i.e., Dizziness - no stairs climbing): _____
_____
Physician's Name & Number: _____ (____) _____

(Attach another page if needed)