

McLaren Print System Order

Order No: 54430 Reprint Previous Order No: 7367
 Order Date: 2020-05-27
 User: Shannon Pierce
 Phone: 8106677040

Ship Location: Lapeer Occupational Health
 1181 S Lapeer Rd
 Lapeer, MI 48446

Forms

Quantity: 100
 Paragon Dept No: 65100
 Dept Name: Lapeer Occ Health
 Company Number: 810

Order Total Price: 4.98

Item Number: MM-1
 Item Description: Employer Authorization for Treatment
 Revision Date: 10/2019
 Print: 2 sided black and white
 Paper: 20# Blue Text
 Size: 8.5 x 11
 Fold:
 Finish:
 Drill:
 Misc Info:

McLaren Medical Group
EMPLOYER AUTHORIZATION FOR TREATMENT

Please complete and sign below. Send form with employee or fax prior to visit.
 Employee should come prepared with photo ID, social security number, eyeglasses for physical exams.

Employee Name: _____
 Date of Visit: ____/____/____ EOB: _____
 Employer: _____ Employee Phone Number: _____
 Address: _____

| | |
|---|--|
| <input type="checkbox"/> PRE-PLACEMENT SERVICES _____ PHYSICAL EXAM ____ Basic ____ DOT ____ Respiratory Med. Clearance ____ Other _____ _____ DRUG SCREEN ____ DOT ____ Non-DOT _____ DRUG SCREEN COLLECTION ONLY ____ DOT ____ Non-DOT _____ URU SERVICE _____ X-RAY ____ Chest - 1 view ____ Chest - 2 view ____ Chest - 1 view/3 reader ____ Back - 2 view _____ BKG _____ AUDIOGRAM _____ PFT (Pulmonary Function Test) _____ BACK SCREEN (Strength and Flexibility) _____ TB SKIN TEST _____ HEP B VACCINE _____ OTHER _____ | <input type="checkbox"/> INJURY (WORK RELATED) <input type="checkbox"/> RETURN TO WORK EXAM <input type="checkbox"/> OTHER: _____ <input type="checkbox"/> DRUG/ALCOHOL SCREENING (Other Than Pre-placement) DRUG SCREEN (urine Test) _____ WITH URU SERVICE _____ COLLECTION/SURVEY ONLY ____ BAC/KCM ____ POST-ACCIDENT ____ FOLLOW-UP ____ FOR-CAUSE/REASONABLE SUSPICION ____ RETURN TO DUTY ____ OTHER _____ BREATH ALCOHOL TEST ____ DOT _____ Non-DOT ____ BAC/KCM ____ POST-ACCIDENT ____ FOLLOW-UP ____ FOR-CAUSE/REASONABLE SUSPICION ____ RETURN TO DUTY ____ OTHER _____ |
|---|--|

SPECIAL INSTRUCTION: _____

By signing and authorizing this service, I agree that fees for services will be paid by the employer.
 AUTHORIZED SIGNATURE: _____ DATE: ____/____/____
 PRINTED NAME: _____

** This authorization is valid for the date stated above unless otherwise noted **

EMPLOYER AUTHORIZATION FOR TREATMENT SEE BACK FOR SPECIFIC SITE INFORMATION