McLaren Business Products

**McLaren Print System Order**

**Order No: 55742 Reprint Previous Order No: 7367**
**Order Date: 2020-07-29**
**User: Shannon Pierce**
**Phone: 810-667-7040**

**Ship Location: Lapeer Occupational Health**
**1181 S Lapeer**
**Lapeer, MI 48446**
**Forms**
**Quantity: 500**
**Paragon Dept No: 65100**
**Dept Name: Lapeer Occ Health**
**Company Number: 810**

**Order Total Price: 24.90**

**Item Number: MM-1**
**Item Description: Employer Authorization for Treatment**
**Revision Date: 7/2020**
**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: ____ / ____ / ____ SSN: _____
Employer: _____ Employer Phone Number: _____
Address: _____

☐ PRE-PLACEMENT SERVICES
____ PHYSICAL EXAM
____ Basic
____ DOT
____ Respiratory Med. Clearance
____ Other: _____
____ DRUG SCREEN
____ DOT
____ Non-DOT
____ DRUG SCREEN -COLLECTION ONLY
____ DOT
____ Non-DOT
____ MRO SERVICE
____ X-RAY
____ Chest - 1 view
____ Chest - 2 view
____ Chest - 1 view/B reader
____ Back - 2 view
____ EKG
____ AUDIOGRAM
____ PFT (Pulmonary Function Test)
____ BACK SCREEN (Strength and Flexibility)
____ TB SKIN TEST
____ HEP B VACCINE
____ OTHER: _____

☐ INJURY (WORK RELATED)
☐ RETURN TO WORK EXAM
☐ OTHER: _____

☐ DRUG/ALCOHOL SCREENING
(Other Than Pre-placement)

DRUG SCREEN (Urine Test)
____ WITH MRO SERVICE
____ COLLECTION SERVICE ONLY
____ RANDOM
____ POST-ACCIDENT
____ FOLLOW-UP
____ FOR CAUSE/REASONABLE SUSPICION
____ RETURN TO DUTY
____ OTHER: _____

BREATH ALCOHOL TEST
____ DOT ____ Non-DOT
____ RANDOM
____ 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
MM-1 (7/20)

SEE BACK FOR SPECIFIC SITE INFORMATION