

McLaren Print System Order

Order No: 8274 Reprint Previous Order No: 7367
 Order Date: 2015-01-16
 User: Kelly Lewis
 Phone: 810-496-0916

Ship Location: Grand Blanc Occ - Kelly Lewis
 2313 E. Hill Rd.
 Grand Blanc , MI 48439

Forms

Quantity: 2500
 Paragon Dept No: 64100
 Dept Name: Grand Blanc Occ
 Company Number: 810

Order Total Price: 113.00

Item Number: MM-1
 Item Description: Employer Authorization for Treatment
 Revision Date: 12/2014
 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 Birth: ____/____/____ F ____ M ____ SSN: _____
 Employer: _____ Employer 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 _____ MRO SERVICE _____ X-RAY _____ Chest - 1 view _____ Chest - 2 view _____ Chest - 1 view/8 leader _____ Back - 2 view _____ ERG _____ 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"/> BRUISING/CONCUSSION SCREENING (Other than Pre-placement) _____ DRUG SCREEN (Same Test) _____ WITH MRO SERVICE _____ COLLECTION SERVICE ONLY _____ BRUISING _____ POST-ACCIDENT _____ FOLLOW-UP _____ FOR CAUSE/REASONABLE SUSPICION _____ RETURN TO DUTY _____ OTHER: _____ BREATH ALCOHOL TEST _____ DOT _____ Non-DOT _____ BRUISING _____ 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 08/1/2014
SEE BACK FOR SPECIFIC SITE INFORMATION