McLaren Business Products

McLaren Print System Order

Order No: 49238 Reprint Previous Order No: 7367
Order Date: 2019-10-04
User: Kelly Lewis
Phone: 810-496-0916

Ship Location: Midland Occupational and Convenient Care
801 Joe Mann Blvd. Suite A
Midland, MI 48642
Forms
Quantity: 500
Paragon Dept No: 56052
Dept Name: Midland Occupational and Convenient Care
Company Number: 810

Order Total Price: 24.90

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: ___ / ___ / ___ 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

SEE BACK FOR SPECIFIC SITE INFORMATION