

McLaren Print System Order

Order No: 55739 Reprint Previous Order No: 7367
 Order Date: 2020-07-29
 User: Shannon Pierce
 Phone: 8104960900

Ship Location: Grand Blanc Occupational and Convenient Care
 2313 E Hill Rd
 Grand Blanc, MI 48439

Forms

Quantity: 100
 Paragon Dept No: 64100
 Dept Name: Grand Blanc Occupational and Convenient Care
 Company Number: 810

Order Total Price: 4.98

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: _____ Employee Phone Number: _____
 Address: _____

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

MM-1 (2/04)