McLaren Business Products

McLaren Print System Order

Order No: 46318 Reprint Previous Order No: 7367
Order Date: 2019-06-19
User: Shannon Pierce
Phone: 810-496-0900

Ship Location: Grand Blanc Occupational and Convenient Care
2313 E Hill Rd
Grand Blanc, MI 48439
Forms
Quantity: 500
Paragon Dept No: 64100
Dept Name: Grand Blanc Occupational and Convenient Care
Company Number: 810

Order Total Price: 24.90

Item Number: MM-1
Item Description: Employer Authorization for Treatment
Revision Date: 10/2016
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
____ WRO 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 WRO 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 10/16

SEE BACK FOR SPECIFIC SITE INFORMATION