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. ****