

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: ____ Greater Michigan Construction Academy ____ Employer Phone Number: __ (989)832-8879 ____
Address: _____ 7730 W. Wackerly St. Midland, MI 48642 _____

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**