OCCUPATIONAL HEALTH SERVICES

Authorization For Treatment and Billing

❑Bruce Twp, 80650 Van Dyke	❑Chesterfield, 30795 23 Mile	❑Fraser, 15717 15 Mile	❑Shelby, 50505 Schoenherr	❑Harbor Town, 3300 E Jefferson	❑Brownstown
Bruce Twp. 48065	Chesterfield, MI 48047	Fraser, MI 48026	Ste. 160, Shelby Twp. 48315	Ste. 100, Detroit, MI 48207	23050 West Rd #220
(810) 798-6480	(586) 421-3065	(586) 285-3825	(586) 323-4712	(313) 656-1618	48183 (734) 287-1412

COMPANY INFORMATION

Company name: ***RICHMOND COMMUNITY SCHOOLS***

Address: ***35276 DIVISION***	City: ***RICHMOND***	State: ***MI***	Zip code: ***48062***

Phone number: (***586***) ***727-3565***	Fax number: (***586***) ***727-2098***	Designated Employer Representative: ***BRIAN J. WALMSLEY, SUPERINTENDENT*** ***JAMIE THIEL, ADMINISTRATIVE ASSISTANT***

Workers Compensation Carrier: ***SET-SEG***	Phone number: (***517***) ***482-0871***

Address: ***415 WEST KALAMAZO STREET***	City: ***LANSING***	State: ***MI***	Zip code: ***48933***

Authorized by:	Title:	Verbal authorization had to be obtained: ❑ Yes By: Date/Time:

EMPLOYEE INFORMATION

Name:	Date of birth:	Job Title:

SERVICES REQUESTED *See Letter Of Understanding for complete list of company protocols*

Reason for testing

- ❑ Pre-Employment
- ❑ Reasonable suspicion
- ❑ Recertification
- ❑ Annual
- ❑ Fit for Duty
- ❑ Follow – up
- ❑ Random
- ❑ Post-accident
- ❑ Other ____________________________

❑ **Work Injury**

Physical Examinations

- ❑ DOT
- ❑ Basic Physical
- ❑ Other ____________________

Drug Testing & BAT

- ❑ 5 Panel
- ❑ 10 Panel
- ❑ DOT
- ❑ Instant
- ❑ Hair - collection
- ❑ BAT
- ❑ Other:______________

Breath Alcohol Testing

- ❑ DOT Federal Breath Alcohol Test
- ❑ Non-DOT Breath Alcohol Test

Other

- ❑ TB testing
- ❑ Audiogram
- ❑ Immunization
- ❑ Titer Type_________________________
- ❑ Pulmonary Function Test
- ❑ X-ray, single view
- ❑ Other: _____________________________

CONSENT TO TREAT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby give consent to Henry Ford Health System Occupational Health Services and the attending physician for examination and treatment. I also authorize release of information pertaining to this specific treatment, physical examination and testing to my employer or entity that ordered and authorized these tests.

Employee / Client Signature	Date:

CONSENT FOR DRUG AND ALCOHOL TESTING AND AUTHORIZATION TO RELEASE INFORMATION

In the event that I am subject to the following drug and alcohol testing, I hereby give my consent to Henry Ford Health System Occupational Health Services to take samples and further give consent to the same facility to forward the sample to the laboratory to perform drug testing on such samples. I further give my permission to release the result of such test(s) to Henry Ford Health System Occupational Health Services and authorized company management.

Employee/Client Signature____ Date: _____________________

Witness Signature: ____ Date: _____________________

THIS SECTION FOR HFHS STAFF ONLY

DIAGNOSIS / TREATMENT and **RECOMMENDATION**

- ☐ May return to regular work with / without restriction Date: ________________________
- ☐ Restrictions:____ ____
- ☐ Resume regular work on ________________________(date)
- ☐ As much as Splint/Bandage permits
- ☐ No work: Estimated date of return (date) _________________
- ☐ Other (explain) ____

Results of Pre-Employment Exam

- ☐ Approved
- ☐ NOT Approved: reason____
- ☐ Approved conditionally, reason:____ ____

DISPOSITION

- ☐ Return to work (date) ________________
- ☐ Sent home (date) ____________________
- ☐ Return to clinic on (date) ___________________
- ☐ Discharge to Company (date) ________________

Signature of Provider_________________________________ **Time in** ___________ **Time of discharge** ___________

Company Contacted (yes/signature) phone / fax ______________________________ **(left message/initials)** _______