Treatment Authorization

MidMichigan Health

Employee Name: _____ SS#: _____ D.O.B: _____

Company Name: _____ Date: _____

Authorized By: _____ Title: _____
Print Name

Phone: _____ Fax: _____

Appointment

Date: ____/____/____ Time: _____ ☐ AM ☐ PM

** Picture I.D. required. If you wear glasses, please bring them.*

Injury

Nature of Injury: _____ Injury Date: ____/____

Physical Exam

☐ Pre-Employment Physical
☐ DOT Physical
☐ Expanded Physical
☐ Flight Physical (Gratiot Only)

By Appointment Only

☐ Company Specific Physical and Functional Assessment
☐ Strength and Flexibility Assessment
☐ Fit for Duty Exam
☐ Other (please specify) _____

Drug Testing

☐ Non - DOT Urine Drug Screen ☐ DOT Urine Drug Screen ☐ Hair Drug Collection ☐ Collect Only
☐ Non - DOT Breath Alcohol* ☐ DOT Breath Alcohol* ☐ Rapid Drug Test
☐ Other: _____

Reason For Test

☐ Pre-employment ☐ Random ☐ Post - Accident ☐ Reasonable Suspicion/For Cause
☐ Return to Duty ☐ Follow Up ☐ Other: _____

Respirator Fit Testing*

☐ Respirator Fit Testing ☐ Respirator Medical Evaluation
☐ Respirator Questionnaire ☐ Mask Fit Only

By Appointment Only

Other Services

☐ Audiogram (OSHA hearing test)
☐ TB Test
☐ Hepatitis B Vaccine
☐ Vision Screening

☐ PFT * Not Houghton Lake
☐ L.S. Spine X-ray _____ View
☐ Other: _____

Staff Signature: _____ Date: _____

Distribution: Original - Medical Record

Revised 4/3/2018

Occupational Health