

Treatment Authorization

MidMichigan Health

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Employee Name: _____ SS#: _____ D.O.B: _____
Company Name: Central State Community Services Date: _____
Authorized By: Kari Conner Title: Human Resources Manager
Phone: 989-631-6691 Print Name Fax: 989-631-8760

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



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Occupational Health