MEDICAL AUTHORIZATION

(Treatment of work-related injury/illness)

RETURN TO: GRAND TRAVERSE COUNTY, HUMAN RESOURCES DEPT
400 BOARDMAN, TRAVERSE CITY, MI 49684 (231) 922-4599

PLEASE RENDER NECESSARY TREATMENT TO ____

WHO ALLEGES A WORK RELATED INJURY ON ____

NATURE OF THE INJURY ____

DESCRIPTION OF ACCIDENT ____

DATE OF BIRTH__________________________LAST 4 DIGITS OF SSN_______________________

JOB TITLE___________________________ DEPARTMENT _________________________________

HOME ADDRESS___________________________________ HOME PHONE_____________________

SUPERVISOR'S SIGNATURE________________________________ DATE_____________________

- D O N O T S E P A R A T E -

Doctor's Report: Please complete the information below and fax the form to (231)922-4796 (secured fax) immediately after the first visit. Your report is necessary before compensation can be determined for the injured employee. It is also required to insure prompt settlement of your bill.

DIAGNOSIS____

TREATMENT RENDERED____

IS FURTHER TREATMENT NECESSARY?_______________ IF YES, WHAT TYPE?_____________

REFERRED TO PHYSICIAN? YES________OR NO________ WHO?_______________________

SPECIAL INSTRUCTIONS____

EMPLOYEE MAY RETURN TO WORK AS FOLLOWS:

TODAY, NO RESTRICTIONS
TODAY, WITH RESTRICTIONS (SEE BELOW)
TOMORROW, NO RESTRICTIONS
TOMORROW, WITH RESTRICTIONS (SEE BELOW)
OTHER, SPECIFY____

RESTRICTION SPECIFICATIONS____

____

DATE_________________________ PHYSICIAN____

PER088 (02/19)