IMLAY CITY COMMUNITY SCHOOLS
634 BORLAND RD IMLAY CITY, MI 48444

INITIAL AUTHORIZATION TO TREAT FORM

All additional treatments/services beyond first visit need approval from CCMSI.

Employer: please complete this form and send with employee for work-related injury.

Employee Information		
Name:		Date:
Date of birth:	Social Security number:	
Location where accident/injury occurred:		
Date of injury:	Injured body part(s):	
Brief description of injury/accident:		
Employer Information		
Employer: Imlay City Community Schools		
Phone: 810-721-9494	Fax: 810-724-4307	
Address:634 W. Borland Rd. Imlay City, MI 48444		
Authorized signature:	Printed name & title:	
The employer accepts responsibility and authorizes initial treatment, including diagnostic testing, for the employee listed above under a self-insured workers' compensation program managed by a third-party administrator. The employee is to be treated for injuries under the provisions of the Michigan Worker's Disability Compensation Act.		
Billing Information		
Workers' compensation insurance/third-party administrator: Cannon Cochran Management Services Inc. (CCMSI)		
Billing address: 2364 Woodlake Drive, Ste. 100, Okemos, MI 48864		
Phone: 517.347.2331	Fax: 217.477.5970	Claim number:
All additional treatments/services beyond initial visit need approval from CCMSI. *The employer, via CCMSI, will pay related and reasonable charges provided that these charges are accompanied by medical records submitted directly to CCMSI. The patient is financially responsible for all other services unless otherwise authorized. *Please be sure to indicate the clinic chosen by employee.**		

Medical Clinic Options (1)	**Medical Clinic Options (1)**
Henry Ford Macomb Health Center-Urgent Care 80650 Van Dyke Rd. Bruce Twp., MI 48065 *(810) 798-6410* Hours: Monday-Friday 8:00am-8:00pm Saturday & Sunday 9:00am-5:00pm	

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District name: Imlay City Community Schools		
Employee name:		
Medical Diagnosis *(to be completed by medical provider)*		
Injured body part(s):		
Medical diagnosis:		
Is condition work related? ☐ No ☐ Yes	Is employee able to return to work full duty? ☐ No ☐ Yes	Is employee fully disabled? ☐ No ☐ Yes
If unable to perform full duties, please specify restrictions:		
If employee is fully disabled, what is the estimated time away from work?		
Physician name (please print):	Phone:	
Address:		
Physician's signature:	Date:	
Date & time of next office visit:		
Please note - all additional treatments/services beyond initial visit need approval from CCMSI. The patient is financially responsible for all other services unless otherwise authorized.		

When completed, please fax to:

Imlay City Community Schools
Attn: Dawn Katkic
634 Borland Rd. Imlay City, MI 48444
Phone: 810-721-9494
Fax: 810-724-4307

Authorization For Treatment Form

HENRY FORD HEALTH

Central Scheduling/Access 1-877-298-3350

❑ Chesterfield	❑ Fraser	❑ Harbor Town	❑ West Bloomfield	❑ Royal Oak
586-421-3065	586-285-3825	313-656-1618	877-298-3350	877-298-3350

COMPANY INFORMATION

Company name: Imlay City Community Schools

Address: 634 W. Borland Rd | City: Imlay City | State: MI | Zip code: 48444

Phone number: (810) 721-9494 | Fax number: (810) 734-4307 | Designated Employer Representative: Dawn Katkic

Workers Compensation Carrier: Cannon Cochran Management Services (CCMSI) | Phone number: (517) 347-2331

Address: 2364 Woodlake Drive Ste.100 | City: Okemos | State: MI | Zip code: 48864

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** ***please indicate if post-accident testing is required***

Brief description of 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 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 of discharge** ______________

Company Contacted (yes/signature) phone / fax ______________________(left message/signature) ______________

Revised 10.2019