McLaren
PORT HURON

Industrial Health

1644 Stone Street
Port Huron, MI 48060
tel (810) 982-8016 | fax (810) 982-3590

Medical Authorization Form

Date: _____

Please call the clinic before sending an employee for a physical or injury/illness treatment. No call is necessary for drug or alcohol screens. Please send this authorization form to the clinic with the employee.

Patient Name: _____ Appointment date and time: _____

Employer: _____ Agency (If a temporary employee): _____

Employer Contact Phone: _____

Authorized by: _____
Print Officer or Designated Employer Representative *Signature*

By signing this authorization, the above referenced employer acknowledges and agrees that it is financially responsible for all incurred charges, whether work related or non-work related.

☐ **Injury and/or Illness** *Please Specify injury/illness to be treated:*	_____ _____
Physical Exams ☐ **Employee to pay**	☐ Pre-placement ☐ DOT - Driver Medical Exam ☐ Annual ☐ Respiratory Clearance (includes physical exam and pulmonary function test) ☐ PIV ☐ Return to Work Exam ☐ Fit for Duty Exam ☐ Other: _____
Non - Federal Drug Screen *Panel (Please Specify):* *Type (Please Specify):* *Reason (Please Specify):* ☐ **Employee to pay**	☐ **5 Panel** ☐ **10 Panel** ☐ **Collection only** (employer's form) ☐ **Instant** (Instant report on negative screen) ☐ **Non-Instant** (Send to lab for testing) ☐ Pre-Placement ☐ Post accident ☐ Reasonable suspicion ☐ Random ☐ Follow-up
Federal Drug Screen *Department (Please Specify):* *Agency (Please Specify):* *Reason (Please Specify):*	☐ DOT ☐ Other: _____ ☐FMCSA ☐FAA ☐FRA ☐ FTA ☐PHMSA ☐USCG ☐ Pre-Placement ☐ Post accident ☐ Reasonable suspicion ☐ Random ☐ Follow-up
Breath Alcohol Testing *Type (Please Specify):* *Reason (Please Specify):*	☐ **DOT** ☐ **Non-DOT** ☐ Pre-Placement ☐ Post accident ☐ Reasonable suspicion ☐ Random ☐ Follow-up
Immunization ☐ **Employee to pay**	☐ Hepatitis B ☐ TB ☐ Flu Shot
Other Service	☐ Audiometer ☐ Hepatitis B Titer ☐ Fit Test Only ☐ Vision ☐ Other: _____