MEDICAL AUTHORIZATION

(treatment of work-related injury/illness)

PLEASE RETURN TO:
Grand Traverse County, HR Dept., 400 Boardman Ave., Suite 309, Traverse City, MI 49684
Fax: 231-922-4796

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	

---------- **DO NOT SEPARATE** ----------

Doctor's Report: Please complete the information below and fax the form to (231)922-4796 (secure 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		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 _____