



St. Joseph Health System
110 Beech #A P.O. Box 489
Tawas City, MI 48764-0489
Phone 989-362-9406 Fax 989-362-9494

AUTHORIZATION FOR TREATMENT & BILLING

Applicant or Employee: _____
Last Name First Name

Employer _____

Employer Address _____
Street City/State Zip Code

Phone Number _____

You have been authorized to be seen for:

- Work Related Injury / Illness (suspected)
- Pre-Placement Examination
- Determination of work-relatedness (Employer will pay for this examination)
- DOT Exam: New Hire Re-Certification
- Impairment Examination (Physical Exam)
- Return to work exam (for personal medical reason)
- Return to work (from lay-off)
- Biological Monitoring Exam (Exposure Cases, i.e. Lead, Asbestos, Pesticides, Heavy Metals)
- Workers Compensation Disability Evaluation
- Other _____

Photo ID required for all drug screens.

- Pre-placement drug screen
 - DOT drug screen
 - Post Accid./Probable Cause DOT
 - Post Accid./Probable Cause Non-DOT
 - Random Drug Screen
 - DOT Non-DOT
 - MRO
 - Drug screen collection only
 - DOT Non-DOT
 - Breath Alcohol Test
 - Blood Alcohol
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- Bill Employer
 - Bill Insurance Company
 - Self Pay - Employee

Employer Authorization: _____
Name (printed) Signature/Title

PATIENT CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize St. Joseph Health System Occupational Health Department for treatment and examination. I also authorize St. Joseph Health System to release any information pertaining to this specific injury or physical examination to my employer, prospective employer, or employer's insurer.

Applicant or Employee Signature Date