Occupational Health-Authorization for Treatment Work-Related Injury or Illness

Please send the authorization for treatment with employee for initial visit

Date: _____/_____/_____

Employee Info

Employee Name: _____

Employee DOB: _____ SSN: _____

Type of Injury: _____

Treatment being requested: _____

Employer Info

Employer: _____

Employer Address: _____

Employer Phone #: _____ Employer Fax #: _____

Title of Authorized Individual: _____

_____ _____

Name of Authorized Individual Signature of Authorized Individual

Workman's Comp Carrier Info

Workman's Comp Carrier: _____

Billing Address: _____

Phone #: _____ Fax #: _____ Claim #: _____

If this is an Emergency or you need to be seen during non-clinic hours, please proceed to one of our Aspire Emergency Departments located in Cass City, Deckerville or Marlette, Michigan.

If you have any questions, please contact Occupational Health at 989-912-6483 or occhealth.dpt@aspirerhs.org