Concentra™

## EMPLOYER'S AUTHORIZATION FOR EXAMINATION OR TREATMENT

*(MUST PRESENT PHOTO ID AT TIME OF SERVICE)*

PATIENT NAME:_____ SSN:_____

COMPANY NAME: **Dearborn Public Schools** DATE OF BIRTH:_____

ADDRESS: **18700 Audette Street, Dearborn, MI 48124** DATE OF INJURY:_____

LOCATION: _____

**WORK-RELATED ___INJURY___ILLNESS**

**SERVICE PACKAGES COMPANY PAY**

___ Hepatitis B 1st Injection
___ Hepatitis B 2nd Injection
___ Hepatitis B 3rd Injection
___ Regulated Collect Preplacment
___ Regulated Collect Random
___ Regulated Collect Post Accident
___ Regulated Collect Reasonable Cause
___ NON Regulated Collect Preplacment
___ NON Regulated Collect Random
___ NON Regulated Collect Post Accident
___ NON Regulated Collect Reasonable Cause
___ Breath Alcohol Test Random
___ Breath Alcohol Test Reasonable Cause
___ Breath Alcohol Test Post Accident

**SERVICE PACKAGES PATIENT PAY**

___ Physical w/ TB Test

**OTHER SERVICES**

____ _____
____ _____
____ _____

Authorized By:_____ Title:_____

Phone:_____ Date:_____