

Alpena-Montmorency-Alcona Educational Service District

Authority for Treatment

Administrator: Complete top portion of this form and give to employee to take with them to emergency room/doctor authorizing treatment for a work-related injury.

To: Doctor _____ Date: _____

From: Alpena-Montmorency-Alcona Educational Service District, 2118 US 23 South, Alpena, MI 49707

Please render the necessary treatment to (Employee Name): _____

Date of Birth: _____ Social Security No.: _____ Phone No.: _____

Who alleges a workplace injury on (date): _____

Nature of Injury: _____

Description of Accident: _____

Administrator's Signature: _____

Doctor: Please complete the following.

Employer name: Alpena-Montmorency-Alcona Educational Service District

Employee name: _____

Medical Diagnosis: _____

Total Disability? Yes ___ No ___ Estimated length: _____

Next Appointment: _____

Can employee return to work with restrictions? Yes ___ No ___ Is condition work related? Yes ___ No ___

Specific restrictions: _____

Physician name (print): _____

Address: _____ Phone: _____

Physician signature: _____

Return to: Alpena-Montmorency-Alcona Educational Service District
ATTN: Business Office
2118 US 23 South
Alpena, MI 49707
Phone: 989-354-3101
FAX: 989-356-3385