PATIENT STICKER

Allegan General Hospital Allegan Professional Health Services

555 Linn Street · Allegan, Michigan · 49010

Authorization For Treatment

You may fax this authorization to the appropriate department or have your employee carry it to their visit.

Company Name	HOPKINS PUBLIC SCHOOLS
Company Address	400 CLARK STREET, HOPKINS, MI 49328
Manager/Supervisor Authorizing Treatment	
Authorizing Individuals' Telephone Number	
Name of Employee to Treat (printed)	
Employee's Date of Birth	

☐ **Treat a Work Related Injury (make sure you mark one of the three boxes below)**

Your employee should report to the following location for treatment:

- ☐ Allegan Occupational Health (Monday - Friday 7:30 am -12:00 pm & 1:00 pm - 4:30 pm)
- ☐ Allegan Walk-In Center (Monday - Friday 4:30pm - 8:00 pm & Saturday 8:00 am-12:00 pm)
- ☐ Allegan General Hospital Emergency Department (Open 24/7)

☐ **Provide Non-Injury Related Services at Occupational Health**

*** Physicals require an appointment with Occupational Health-please call (269) 686-4270.**

**** Drug screens, TB tests, and immunizations are available by walk-in: M-F 7:30-11:30am and 1-4pm.**

Pre-Placement or Annual Testing	DOT Services	Immunizations**
☐ Pre-employment physical*	☐ DOT Physical*	☐ Tdap
☐ Back Evaluation	☐ Urine Drug Screen	☐ Td
☐ Urine Drug Screen	☐ Breath Alcohol Test	☐ Hepatitis B
☐ Breath Alcohol Test	☐ Other: ____________	☐ TB
☐ Pulmonary Function Test	____________	☐ Flu Vaccination
☐ TB Skin Test** **(Not given on Thursdays)**		
☐ Hepatitis B		
☐ Other: ____________		

Screenings

☐ Urine Drug Screen**	☐ Federal	☐ Non-Federal
☐ Breath Alcohol Test	☐ Federal	☐ Non-Federal
☐ Nicotine Testing		
☐ Chest X-ray		

Allegan Occupational Health	Allegan Walk-In Center	Allegan Emergency Department
551 Linn Street, Suite 150	**551 Linn Street, Suite 150**	**555 Linn Street**
Allegan, MI 49010	**Allegan, MI 49010**	**Allegan, MI 49010**
Phone: (269) 686-4270	**Phone: (269) 686-5858**	**Phone: (269) 686-4020**
Fax: (269) 686-4305	**Fax: (269) 686-4305**	**Fax: (269) 686-4337**

Revision: 10/27/2014
Department Telephone: See Individuals Department List Above
Authorization for Treatment – Industrial Medicine

LOSS CONTROL REVIEW

SEG SELF-INSURER
WORKERS' COMPENSATION FUND

EMPLOYEE'S REPORT OF INJURY

PERSONAL INFORMATION

NAME _______________ CLAIM # _______________

ADDRESS _______________ HOME PHONE _______________ CELL PHONE _______________

Gender: ○ MALE ○ FEMALE

DATE OF BIRTH _______________ SOCIAL SECURITY NUMBER _______________

OCCUPATION _______________ EMPLOYER _______________ DEPARTMENT _______________

EMPLOYER ADDRESS _______________

NUMBER OF DAYS PER WEEK _______________ NUMBER OF HOURS PER DAY _______________ NORMAL DAYS OFF _______________

LENGTH OF EMPLOYMENT _______________ WAGES (HOURLY RATE OF PAY) _______________

INJURY INFORMATION

DATE OF INJURY _______________ TIME _______________ DATE INJURY REPORTED _______________

Accident reported to: _______________ By (name): _______________

Who witnessed accident (name & address for each person listed)? _______________

Describe fully how injury happened (continue on back if necessary): _______________

What part(s) of your body was injured? _______________

Did you stop work as a result of your accident? ○ YES ○ NO When: _______________

Was your pay continued during any part of your disability? ○ YES ○ NO

If so, for what period? _______________ Last day for which you were paid? _______________

If not working, date you expect to return to work? _______________ If you did return to work, list date? _______________

From whom did you receive first medical treatment (list date)? _______________

Are you still under medical treatment? _______________ How often do you receive treatment? _______________

NAME OF DOCTOR _______________ ADDRESS _______________ PHONE _______________

SIGNATURE

SIGNATURE _______________ DATE _______________ CLAIM # _______________

LOSS CONTROL REVIEW

SEG SELF-INSURER
WORKERS' COMPENSATION FUND

SUPERVISOR'S REPORT OF ACCIDENT

SCHOOL DISTRICT INFORMATION

NAME OF SCHOOL DISTRICT

MAILING ADDRESS

DIVISION | LOCATION | PHONE

EMPLOYEE INFORMATION

EMPLOYEE'S NAME: FIRST, MIDDLE, LAST

HOME ADDRESS

HOME PHONE | CELL PHONE

DATE OF BIRTH | GENDER ○ MALE ○ FEMALE | SOCIAL SECURITY NUMBER

OCCUPATION | DEPARTMENT

ACCIDENT INFORMATION

DATE OF ACCIDENT | TIME OF ACCIDENT ○ A.M. ○ P.M. | REGULAR WORK?

Describe injury: ______________________

Body part injured: ______________________

Witness info: ______________________

Fatality? ○ YES ○ NO

How did the accident happen? ______________________

Employment date: ______________ How long on this job? ______________

Detail all machine or equipment involved: ______________________

Specify activity employee was engaged in when accident occurred: ______________________

What safety words or safety equipment was in place? ______________________

What should be done to prevent repetition? ______________________

Has it been done? ○ YES ○ NO If not, give reason: ______________________

NAME OF PHYSICIAN | ADDRESS

NAME OF HOSPITAL | ADDRESS

SIGNATURES

SUPERVISOR'S SIGNATURE | DATE

REVIEWED BY | DATE