ATTACHMENT – F

Please send all invoices directly to FA Industrial Services, Inc.

FA Industrial Services, Inc.
PO Box 366
Iron River, MI 49935
906-265-2100
231-344-5919 Fax

Authorization for Initial Medical Treatment

Employee Name_____ Birth date_____

Employees Address_____ Phone_____

Date of Injury_____

Clinic or Treating Physician_____ Phone_____

Employee shall return white copy to their immediate supervisor after initial exam.

Authorized Supervisor Signature_____ Job Phone_____

Employee Signature for Release of Information to above Employer_____

Physician's Report

The above patient was seen for:
☐Treatment of Initial Injury/Illness ☐First Aid Only ☐Independent Evaluation/Consultation

☐Follow-up care for previous reported injury/illness resulting in a change of ☐Work Status ☐Diagnosis

Time Arrived_____ Time Treated_____ Time Out_____

Diagnosis_____

POST ACCIDENT DRUG TESTING IS A CORPORATE REQUIREMENT. HAS TEST BEEN DONE?

☐ YES ☐ NO If no, Why?_____

The patient is:
☐Discharged for care ☐Able to return to full time work on date _____

☐ Is working at this time ☐Unable to work from_____through _____because of

_____

☐Continuing Pain ☐Medication ☐Infection/Contagion ☐Consult Pending

☐Able to return to modified duty from_____through _____

☐Physical Therapy ☐X-ray taken ☐CT Scan Findings_____

_____

ATTACHMENT – F (continued)

Physical Modifications:

☐To keep wound clean and dry ☐No Kneeling ☐No Crawling ☐Sitting Job Only

☐No climbing or overhead work ☐No operating of equipment

☐Modified operating of equipment: _____Maximum miles/day _____Other

☐Standing: _____ Minutes/Hour _____ Hour/Day

☐Modified Duty/Bending: degree of bending: ☐10-20 ☐20-45 ☐full

Maximum number of times per hour: ☐0-2 ☐2-6 ☐6-10 ☐10-20

☐Lifting, Pushing, and Pulling: Maximum weight in pounds: ☐10 ☐20 ☐30 ☐40 ☐50 ☐60

Maximum number of times per hour: ☐0-2 ☐2-6 ☐6-10 ☐10-20

☐Right hand work only ☐Left and work only

☐No repetitive motion as follows: ☐hand grip ☐wrist motion ☐elbow flexion ☐foot control

Comments_____

_____

Next Physician's Appointment: Date_____ Time_____

Next Therapy Appointment: Date_____ Time_____

Note: All information must be filled in and a copy sent back to the worksite with the injured employee. Given the physical modifications, we will determine whether we have work available for this employee. Please limit appointments for Doctor's visits to maximum of (2) weeks apart.

_____

Physician's Signature Print Name Date