INITIAL AUTHORIZATION TO TREAT FORM

All additional treatments/services beyond first visit need approval from CCMSI.

Employer: please complete this form and send with employee for work-related injury.

Employee Information		
Name:		Date:
Date of birth:	Social Security number:	
Location where accident/injury occurred:		
Date of injury:	Injured body part(s):	
Brief description of injury/accident:		
Employer Information		
Employer: Almont Community Schools		
Phone: 810-673-9104	Fax: 810-798-2367	
Address: 4701 Howland Rd		
Authorized signature: Laura LaBroski	Printed name & title: Laura LaBroski, Accountant	
The employer accepts responsibility and authorizes initial treatment, including diagnostic testing, for the employee listed above under a self-insured workers' compensation program managed by a third-party administrator. The employee is to be treated for injuries under the provisions of the Michigan Worker's Disability Compensation Act.		
Billing Information		
Workers' compensation insurance/third-party administrator: Cannon Cochran Management Services Inc. (CCMSI)		
Billing address: 2455 Woodlake Circle, Okemos, MI 48864		
Phone: 517.347.2331	Fax: 217.477.5970	Claim number:
All additional treatments/services beyond initial visit need approval from CCMSI. *The employer, via CCMSI, will pay related and reasonable charges provided that these charges are accompanied by medical records submitted directly to CCMSI. The patient is financially responsible for all other services unless otherwise authorized.*		
Medical Clinic	**After-hours care**	
Henry Ford Macomb health Center – Bruce Township – Urgent Care *Weekdays: 8 a.m. – 10 p.m.* *Weekends & Holidays: 10 a.m. – 6 p.m.* *(810) 798-6410*	*Henry Ford Macomb health Center – Bruce Township – Urgent Care* *Weekdays: 8 a.m. – 10 p.m.* *Weekends & Holidays: 10 a.m. – 6 p.m.* *(810) 798-6410*	

Please go to page 2

AUTHORIZATION TO TREAT FORM

District name: **Almont Community Schools**		
Employee name:		
Medical Diagnosis *(to be completed by medical provider)*		
Injured body part(s):		
Medical diagnosis:		
Is condition work related? ☐ No ☐ Yes	Is employee able to return to work full duty? ☐ No ☐ Yes	Is employee fully disabled? ☐ No ☐ Yes
If unable to perform full duties, please specify restrictions:		
If employee is fully disabled, what is the estimated time away from work?		
Physician name (please print):		Phone:
Address:		
Physician's signature:		Date:
Date & time of next office visit:		
Please note - all additional treatments/services beyond initial visit need approval from CCMSI. The patient is financially responsible for all other services unless otherwise authorized.		

When completed, please fax to:

Almont Community Schools
Attn: Laura LaBroski
llabroski@almontschools.org
4701 Howland Road, Almont MI 48003
Phone: 810-673-9104
Fax: 810-798-2367

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 # _____

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 | ☐ MALE ☐ FEMALE GENDER | 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