|  |  |  |
| --- | --- | --- |
|  | Michigan Municipal League Worker’s Compensation Fund  3196 Kraft SE, Suite 206  Grand Rapids, Michigan 49512-2065  (616) 942-0311 |  |

**ORDER FOR MEDICAL TREATMENT**

**Dear Doctor:**

**Kindly render first aid service as deemed necessary for proper care of the injury sustained by our employee listed below. Our liability for subsequent treatment is governed by the provisions of the Workers’ Compensation Act.**

***Notice to Surgeon:*** *Please complete and mail the attached report to the employer listed below after employee’s first treatment.*

|  |  |
| --- | --- |
| **THIS SECTION TO BE COMPLETED BY EMPLOYER** | |
| Employee: | Date of Injury: |
| Employer: | Employer Phone: |
| Employer Address: | |
| Employer Contact Authorizing Treatment: | |
| Nature of Injury: | |

|  |  |  |
| --- | --- | --- |
| **THIS SECTION TO BE COMPLETED BY DOCTOR ONLY** | | |
| Employee: | | Date of Injury: |
| Describe Injury and Diagnosis: | | |
| Treatment: | | |
|  | | |
| Will further treatment be required:  YES  NO | | |
| Approximate period of disability, or date employee can return to work: | | |
| Type or Print Name of Doctor: | | |
| Doctor’s Address: | | |
|  | | |
| Doctor’s Telephone: | | |
| Date: | Doctor’s Signature: | |
| **When completed and signed, employee to return this form to employer.** | | |

**PLEASE SEND BILLS TO THE ADDRESS ABOVE**