

Marquette Location:

1414 W. Fair Ave., Suite 35

Marquette, MI 49855

906.449.1140 -New #

FAX: 906.449.1844

[occmed@mghs.org](mailto:occmed@mghs.org) or

[pamela.schmeltzer@mghs.org](mailto:pamela.schmeltzer@mghs.org)

Escanaba Location:

710 S. Lincoln Rd., Suite 800

Escanaba, MI 49829

906.786.0440

FAX: 906.789.8799

[michelle.jupe@mghs.org](mailto:michelle.jupe@mghs.org) or

[pamela.schmeltzer@mghs.org](mailto:pamela.schmeltzer@mghs.org)

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***Please complete this form in its entirety and return before your employee's first appointment***

Employee Full Legal Name: \_\_\_\_\_

Employee Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employee Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_      Employee Claim number: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
\_\_\_\_\_

Employer Telephone #: \_\_\_\_\_

Insurance Co Name: \_\_\_\_\_

Address to Send Claim: \_\_\_\_\_  
\_\_\_\_\_

Insurance Co Telephone # \_\_\_\_\_

Adjustor's Name: \_\_\_\_\_

**Employer Contact / Authorizing Services:**

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_