FERRIS STATE UNIVERSITY
HUMAN RESOURCES

INTENT TO TREAT

Employee's Name_____
(PLEASE PRINT)

From _____ forward I intend to treat with _____
(date of first appointment) (physician/hospital)

_____
(address, city, state zip)

_____
(phone & fax number)

regarding an injury received to my _____ on _____
(body part) (date of injury)

which I claim arose out of or in the course of my employment at Ferris State University.

I hereby authorize and request the above listed physician/hospital to give Ferris State University or any representative thereof, any and all information regarding examinations, diagnosis, prognosis and treatment of the above mentioned injury. A similar intent to treat form will be required prior to treating with a physician or hospital not named above. A photocopy of this authorization shall be considered as effective and valid as the original.

_____
(Employee Signature)

_____
(Date)

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