MICHIGAN STATE
UNIVERSITY

INTENT TO TREAT

Employee Name_____

ZPID or APID_____

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

of _____, regarding an injury received to my _____
(city & state) (body part)

on _____ which I claim arose out of or in the course of my
(date of injury)

employment at Michigan State University.

I hereby authorize and request _____ to give to Michigan
(physician/hospital)

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)

Human Resources

Michigan State University
1407 S. Harrison, Suite 110
East Lansing, MI 48823

517-353-4434
Fax: 517-432-3862
hr.msu.edu