

MICHIGAN STATE
UNIVERSITY

INTENT TO TREAT

Employee's Name _____

Social Security Number _____

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.



**HUMAN
RESOURCES**

Benefits

Michigan State University
Nisbet Building
1407 S Harrison, Suite 140A
East Lansing, Michigan
48823-5287

517/353-4434
FAX: 517/353-1869

www.hr.msu.edu

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

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)