



EMPLOYER'S AUTHORIZATION FOR EXAMINATION OR TREATMENT

Patient/Employee Name: _____

SSN: _____ Date of Birth _____ .

WORK RELATED: INJURY ILLNESS

EMPLOYER: **SITE Staffing, Inc. 809 W. National Avenue., Milwaukee, WI 53204 (414) 383-8084**

SITE Staffing, Inc. has the utmost concern for the well-being and treatment of its people.

Our employee must contact SITE Staffing, Inc. Human Resource Manager, by phone or in person as soon as possible after you have suffered a work related illness or injury to insure proper reporting and payment of the claim.

Failure to do so may result in denial of the claim.

In the event you suffer a work related injury or illness we will provide support to your care and recovery.

SITE Staffing will make every attempt to provide transitional work assignments to meet your restrictions during your recovery

Drug screen & Breath Alcohol Post Accident Reasonable Cause

Authorized By: Barbara E. Maszk, Human Resource Manager SITE Staffing, Inc.

Signature: *Barbara E. Maszk*

Forward test results and a copy of signed form to:

Barbara Maszk
Human Resource Manager
SITE Staffing, Inc.
809 W. National Ave
Milwaukee, WI 53204
(414) 383-8084
(414) 383-8315
bmazsk@sitestaffinginc.com

BILLING:

Employee to pay charges
 Workers' Compensation
Insurance Co:
Argent, a division of West Bend
Mutual Insurance Company
1900 South 18th Ave
West Bend, WI 53547