



Occupational Disability Management Program
DECLINATION OF MEDICAL TREATMENT

This is for use ONLY if the Employee declines medical treatment.

Employee:

- Complete and sign the top portion of the Incident Report.
- Complete and sign the Declination of Medical Treatment form.

Supervisor:

- Review and sign the Declination of Medical Treatment form.
- Complete and sign the bottom portion of the Incident Report.
- Send both completed forms to the Risk Management Officer and a copy to the Safety Officer.



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INCIDENT REPORT

EMPLOYEE COMPLETE TOP PORTION:

EMPLOYEE NAME:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME
JOB TITLE:		DATE OF HIRE:	
HOME TELEPHONE:		DATE OF BIRTH:	
HOME ADDRESS:		DEPARTMENT:	
INCIDENT DATE:	TIME OF INCIDENT:	LOCATION:	
DATE REPORTED:	TIME BEGAN WORK:	INCIDENT REPORTED TO:	
NATURE OF INJURY (e.g., puncture, strain, cut, fracture, burn, etc.):			
BODY PART INJURED (e.g., right wrist, left knee, head, lower back, etc.):			
INJURY SOURCE (e.g., wet pavement, jack hammer, keyboard, etc.):			
HOW INJURY OCCURRED (struck by, fell from, exposed to, etc.):			
WHO WITNESSED THE INCIDENT?			
EMPLOYEE'S STATEMENT OF WHAT OCCURRED:			
SAFETY OFFICER COMMENTS:			
<input type="checkbox"/> I am not filing a Workers' Compensation claim at this time. If I believe I require medical treatment in the future related to this incident, I will immediately inform my Supervisor.			
EMPLOYEE'S SIGNATURE:		DATE:	

SUPERVISOR COMPLETE BOTTOM PORTION:

<input type="checkbox"/> EMPLOYEE DECLINED MEDICAL TREATMENT <input type="checkbox"/> EMPLOYEE RECEIVED MINOR FIRST AID CARE ON SITE. Please complete Declination of Medical Treatment.		
SUPERVISOR:		TITLE:
SIGNATURE:	DATE:	TELEPHONE:

Distribution: Risk Management Officer; Safety Officer
Initiate incident investigation in accordance with the Injury & Illness Prevention Program (IIPP)



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EMPLOYEE: Please check all that apply.

I am not in need of and decline medical treatment at this time.

I have received sufficient on-site first aid care in the form of:

- Application of antiseptics
- Treatment of first-degree burn
- Application of bandage
- Use of elastic bandage
- Removal of foreign bodies not embedded in eye (only irrigation required)
- Removal of foreign bodies from wound (uncomplicated procedure, for example, using tweezers)
- Use of nonprescription medications
- Application of hot or cold compress
- Application of ointments to abrasions to prevent drying or cracking

Print Name: _____

Signature: _____

Date: _____

SUPERVISOR:

Print Name: _____

Signature: _____

Date: _____