Claims Management of Missouri, LLC

# "EMPLOYER INCIDENT REPORT" – FIRST AID ONLY TREATMENT

****Supplemental form to Employers' First Report of Injury – Incident Only Claim ****

**Today's Date:** _____

**Employee:** _____

**Date of Stated Injury:** _____

**Time of Stated Injury:** _____

**Work Schedule /Hours:** _____

**Location of Injury:** _____

**Description of Injury:** _____

**Body Part(s) Affected:** _____

**The above Employee has reported a claim under Workers' Compensation and the Employer has acknowledged and/or treated the Employee as "Visible First Aid" treatment only.**

**The Employer/Employee have acknowledged that any workers' compensation injury that does not constitute "visible first aid" must be directed to an "authorized medical provider" for appropriate medical treatment and post-accident drug/alcohol testing based on the Employer's Company Policy.**

_____ Date: _____
(Employee Signature)

_____ Date: _____
( Employer's Representative )

_____
( Title )

**** Please Note ****
**Should the employee choose to seek medical treatment for a stated Workers' Compenation Injury from any other provider – other than one authorized by their Employer – any/all payments will be at the Employee's own expense.**