

"INCIDENT REPORT" – FIRST AID ONLY TREATMENT FORM****Supplement to Employers' First Report of Injury**

Today's Date: _____

Employee: _____
Date of Stated Injury: _____
Time of Stated Injury: _____
Location of Injury: _____
Description of Injury: _____
Body Part(s) Affected: _____

The above employee has stated that a workers' compensation accident/incident has occurred at the above date, place and time.

At the request of the employee, he/she does not wish to seek the offered medical treatment at our authorized provider for workers' compensation. The Employee has been advised of his/her Mo. workers' compensation benefits in conjunction with the post-accident policy of the employer.

 (Employee Signature) Date: _____

A copy of this form will be provided to the employee and if he/she does wish to seek medical treatment at a future date, the employee is to advise the workers' compensation benefits manager immediately. **Please be advised: This employer "only" authorizes the following facility as our "initial" workers' compensation medical provider:**

AUTHORIZED MEDICAL PROVIDER: _____

 (Employer's Representative)

 (Title)

**** *Please Note* ****

Should the employee choose to seek medical treatment from any other provider (other than what is approved above), all payments will be at the employee's own expense.