GEORGE G. GLENNER
ALZHEIMER'S FAMILY CENTERS, INC.®

EMPLOYEE INCIDENT/ACCIDENT REPORT

Employee Name: _____

Site Address of Injury: _____

Date of Incident/Illness: _____ **Time of Incident/Illness:** _____ **Time Employee Began Work:** _____

Specific incident/accident and part of body affected and medical diagnosis, if available:

_____

_____

_____

On employer's premises: **Yes** ___ **No** _____ **Other workers injured/ill in this event:** **Yes** _____ **No** _____

Specific activity the employee was performing when incident/accident occurred.:

_____

_____

_____

Please mark yes or no
Employee checked by center nurse: **Yes** _____ **No** _____

Nurses Notes: _____

_____

Please initial if necessary:
_____**I am accepting treatment and will go to the doctor immediately.**

DECLINATION OF MEDICAL EXAMINATION/TREATMENT

Please initial the appropriate paragraph:

_____**I AM NOT experiencing any signs or symptoms resulting from the incident/accident described above. Medical treatment has been offered to me; however, I decline any medical evaluation or treatment as a result of this job-related incident/accident. I received the appropriate medical workers compensation paperwork if I feel it necessary to seek medical treatment in the future for this specific incident/accident.**

_____**I AM experiencing signs or symptoms resulting from the incident/accident described above. Medical treatment has been offered to me; however, as I feel my symptoms are improving, I decline any medical evaluation or treatment as a result of this job-related incident/accident. I received the appropriate medical workers compensation paperwork if I feel it necessary to seek medical treatment in the future for this specific incident/accident.**

(If the need for medical treatment arises as a result of this incident/accident, I have been instructed to inform my supervisor immediately.)

Please mark yes or no:
Human Resources Notified: **Yes**_____ **No** _____

Date HR Notified: _____
Date

_____
Employee Signature **Date**

_____
Supervisor Signature **Date**