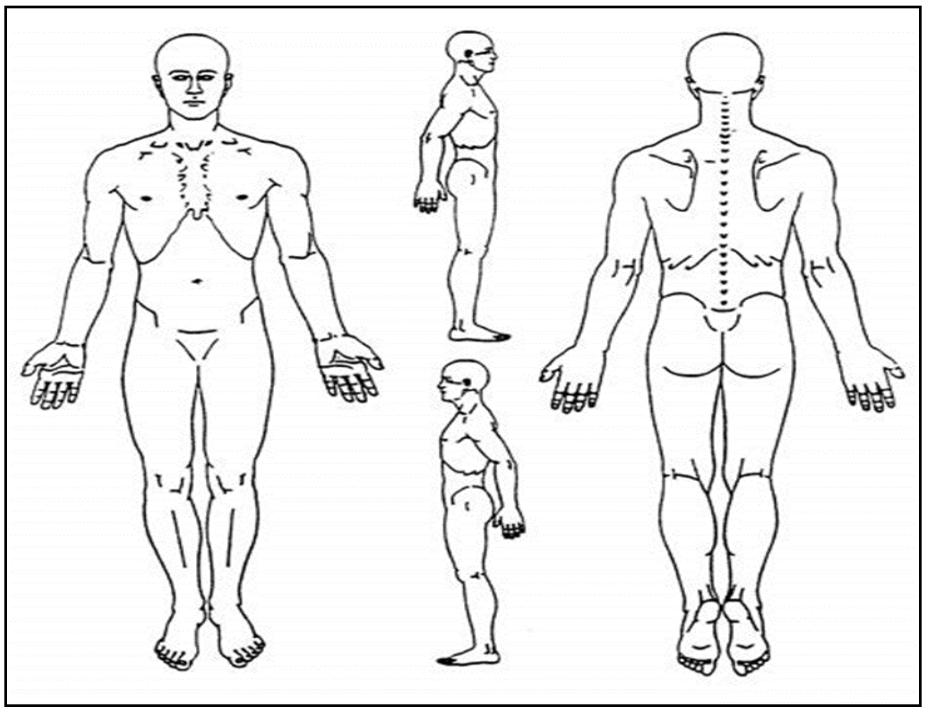
Employee Name:		Date of Incident:	

CIRCLE AREA(S) OF INJURY OR SYMPTOMS AND LIST BELOW



MAIN COMPLAINTS

__ Bruise/Contusion
__ Dislocation
__ Dizziness/Nausea
__ Dull Ache
__ Gastrointestinal Trouble
__ Heat Related
__ Immobile Joint/Appendage
__ Numbness/Tingling
__ Obvious Fracture/Deformity
__ Possible Concussion
__ Respiratory Trouble
__ Skin/Rash/Dermatological
__ Sharp Pain
__ Strain/Sprain
__ Visible Swelling
__ Vision Trouble
__ Wound – Abrasion
__ Wound – Laceration

Describe the injury or illness (body part(s) condition):
Have you ever sustained an injury or illness to this part of your body before? ☐ Yes ☐ No If "Yes," please explain any previous condition that may have been aggravated by this incident:

REQUEST OR DECLINATION OF MEDICAL TREATMENT INITAL (A OR B) BELOW THAT APPLIES.

A. **Medical Treatment Requested:** I am requesting medical treatment for my injury or illness.
Employee initial here: _____

B. **Medical Treatment Declined:** I am reporting the injury or illness for **REPORTING PURPOSES ONLY** and declining medical attention and or treatment at this time therefore I was not provided with a Workers' Compensation Claim Form (DWC-1). If I elect to seek medical attention for the injury or illness, in the future, I will immediately advise my supervisor or employer and will be referred for treatment and be provided with a Workers' Compensation Claim Form (DWC-1) within 24 hours.
Employee initial here: _____

_____ _____
Employee Signature Date