function — of beauty

Declination of Medical Examination and / or Treatment

Injured Information			
Name of Injured:			
Employer : (If other than Function)			
Contact Phone:		Contact Email:	

Injured Address:			
Street:		Apt /Building #:	
City:			
Zip Code:			

Incident and Injury Details			
Date of Incident or Injury:	/ /	Time of Incident or Injury:	
Location of Incident or Injury:			
Description of Incident and / Or Injury Below:			

Please initial your choice from the options below:

_____My signature below confirms that I **am not** experiencing any signs or symptoms resulting from the incident and / or accident described above and that medical treatment has been offered to me, but **I decline** and medical evaluation or treatment as a result.

_____My signature below confirms that **I am** experiencing any signs or symptoms resulting from the incident and / or accident described above and that medical treatment has been offered to me, but **I decline** and medical evaluation or treatment as a result.

If the need for medical treatment arises as a result of this accident and / or injury, I have been instructed to contact ***one or all*** of the following:

- My Supervisor
- Human Resources Department
- Environmental Health & Safety Department

_____ _____

Employee Signature Date

_____ _____

Employer Signature Date

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