

If you are declining medical care you do not have to complete the [XR Employee Injury Report](#) but note that your supervisor must still complete the [XR Supervisor First Report of Injury](#).

Producer/AdAgency/Advertiser Name		Project Name	
Employee Name (Last, First)		Social Security Number	
Street Address		City, State, Zip	
Home Phone		Cell Phone	
Date Injury occurred		Time of injury AM PM	
Direct Supervisor		Job Title	
Please describe the specific injury or illness and the body part affected (i.e. laceration on left hand, right shoulder abrasion, etc)			
How did the accident / exposure occur? Describe the sequence of events; specify the object / exposure which directly produced the injury / illness (i.e. stepped on wet grass and lost balance, landed on my left wrist)			
Date supervisor was notified of injury		Time supervisor was notified of injury AM PM	

By signing this statement I, _____ acknowledge that I have been offered the opportunity to receive medical care for the above mentioned injury(s) but have declined and / or refused at this time. Should I require medical care due to this injury in the future I will promptly advise XR Extreme Reach so that they can direct me to the appropriate Occupational / Industrial medical facility.

Employee's Printed Name	Employee's Signature:	Date
Supervisor's Printed Name	Supervisor's Signature	Date

Workers' Compensation fraud is a felony offense. If you have any suspicions regarding the legitimacy of a claim, please notify the XR Extreme Reach Risk Management department immediately.

Questions? Contact us at riskmanagement@extremereach.com