CLARK ATLANTA UNIVERSITY

Department of Human Resources

Incident/Accident Report

(Please fill out and return to Human Resources within 24 hours)

Faculty ☐ **Staff** ☐ **Student Worker** ☐

Waiver of Medical Treatment
Clark Atlanta University

Employee: ____

Date of Injury: ____

Description of Accident:

____

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____

Specific Body Part(s) Injured:

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My signature confirms that I have voluntarily waived medical treatment for the injury indicated above. Should it later be determined that I require medical treatment for the injury indicated above, I will notify my supervisor prior to seeking treatment and choose a physician from the employer's posted panel, unless emergency treatment is required.

_____________________________________ ____________________

Employee's Signature Date

_____________________________________ ____________________

Supervisor's Name Date

A signed copy of this form should be given to the employee.
The original form should be sent to Human Resources.