WORK COMP REFUSAL OF MEDICAL TREATMENT OR OBSERVATION

Employee's Name: _____ Date Reported: _____ DOB: _____ Social Security Number: _____

Address: _____

Date of Injury: _____ Time of Injury: _____

Supervisor: _____ Client / Location: _____

Witness(es):

_____

Nature of Injury/Condition:

_____

Description of Injury [Body Part(s) Injured]:

_____

Brief Narrative Description of the Incident:

_____
_____
_____

I, hereby acknowledge my refusal of medical treatment and/or observation offered to me at the expense of my employer for the work-related injury I incurred on _____. By signing this form, I realize that I do not necessarily affect my later eligibility for Workers' Compensation.

I acknowledge that my supervisor(s), in good faith, have offered and made available to me an opportunity to seek necessary medical treatment and/or observation. I am aware that by declining medical treatment at this time, that my employer, will not be responsible for any
medical expenses or lost wages.

At a later time, I may request from my employer, via my supervisor, a medical authorization to obtain medical treatment and/or observation for the above described injury.

_____
Employee's Signature

_____
Date

_____
Employee Represenative/Witness