Workers' Compensation Refusal of Medical Treatment

Employee's Name: __________________________ **Date Reported:** __________________________

Date of Injury: ______________________________ **Time of Injury:** ___________________________

Supervisor: ________________________________ **Location:** ______________________________

Witness(es): ____

Description of Injury [Body part(s) injured]:

____

Brief Narrative Description of the Incident:

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I, ___________________________________, hereby acknowledge my refusal of medical treatment and/or observation offered to me at the expense of my employer for my work-related injury I incurred on _______/_________/_______.

I acknowledge that my employer, in good faith, has offered and made available to me an opportunity to seek necessary medical treatment. 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.

I understand that, at a later time, I may request a medical authorization to obtain medical treatment for the above described injury from my supervisor.

_______________________________________ ____________________
Employee Signature Date