

REFUSAL OF TREATMENT

DATE: _____

EMPLOYEE NAME: _____

As of the date noted above I am notifying my employer of an injury that occurred on _____, 200__.

- My supervisor did not receive notification of this incident.
My supervisor did receive notification of this incident on _____, 200__.

This injury, (briefly describe condition) _____

did occur during my normal scope and duties.

At this time I have been requested by my employer to be medically evaluated by a preferred medical provider. However, I decline to be medically evaluated for the above noted condition.

I understand that by signing this document any future claims regarding this injury will require a medical evaluation by the preferred healthcare provider listed below. I also understand that should I decide to seek medical treatment for this injury that I must first notify my supervisor and go to the following provider:

PROVIDER: _____
ADDRESS: _____
PHONE: _____

SHOULD THE CONDITION BECOME LIFE THREATING YOU SHOULD SEEK APPROPRIATE EMERGENCY MEDICAL CARE.

EMPLOYEE STATEMENTS

By signing this form I acknowledge:

I have not sought medical treatment for this injury.

I understand that it is the policy of my employer to have a post-accident drug screen and this refusal of medical treatment does not remove the requirement that I receive a post-accident drug screen.

I have read the above information and agree it is factual and true statement. I authorize any physician, hospital, or healthcare provider to release and furnish any, and all, medical records or other information pertaining to the above listed condition.

Employee Signature
Date

Supervisor / Witness Signature
Date