REFUSAL OF TREATMENT

EMPLOYEE NAME:		DATE:	

As of the date noted above I am notifying my employer of an injury that occurred on

(DATE): _____

- ☐ My supervisor did not receive notification of this incident.
- ☐ My supervisor did receive notification of this incident on (DATE): _____

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-THREATENING 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 any treatment I elect to receive from an unauthorized physician or provider will not be covered under workers' compensation benefits and I will be responsible for any charges incurred for any unauthorized treatment.

I understand that if it is the policy of my employer to have a post-accident drug screen 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 a 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 **Supervisor / Witness Signature**

_____ _____

Date **Date**