Employee's Declination of Medical Treatment

Employee's Name *(print)*: _____

Location Address: _____

Witness (es): _____

Nature of Injury/Condition: _____

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

_____

Brief Narrative Description of the Incident: _____

_____

I, _____ *(employee name)* hereby acknowledge my refusal of medical treatment offered to me by my employer for the possible work-related injury I incurred on _____ *(date)*. By signing this form, I realize that I do not necessarily affect my later eligibility for Workers' Compensation. I acknowledge that my employer, in good faith, has offered and made available to me an opportunity to seek necessary medical treatment.

At a later time, I understand that I may request from my employer's a medical authorization to obtain medical treatment for the above described injury.

Please check all/any that apply:

☐ I decline ALL medical treatment at this time.

☐ I decline the company's advice to seek medical assistance at this time.

_____ _____

Employee's Signature **Date**

_____ _____

Witness/Manager's Signature **Date**