congruity
Your Business Optimized.

Workers' Compensation Refusal of Medical Treatment

Employee Name ____ Date Reported ____________

Date of Injury ____________________ Time of Injury _________________

Supervisor ________________________________ Client/Location _____________________________

Witness(es) ____________________________________

____

Nature of Injury/Condition

____

____

____

Description of Injury [Body Part (s) Injured

____

____

Brief Narrative of Incident

____

____

____

I, ______________________________hereby acknowledge my refusal of medical treatment and/or observation offered to me for the work related injury I incurred on __________________. I acknowledge that my supervisor, in good faith, has offered and made available to me an opportunity to seek 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.

Employee Signature ___________________________ **Date** __________________

Supervisor Signature __________________________ **Date** __________________