WORKERS’ COMPENSATION

REFUSAL OF MEDICAL TREATMENT OR OBSERVATION

FORM

**Employee’s Name (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supervisor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness(es): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nature of Injury/Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Description of Injury: (Body Parts Injured):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Brief Narrative Description of the Incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby acknowledge my refusal of medical**

**treatment and/or observation offered to me at the expense of my employer**

**for the reported work-related injury I incurred on (\_\_\_\_\_\_\_\_\_\_\_\_\_). By**

**signing this form, I realize that I do not necessarily affect my later eligibility for**

**Workers’ Compensation.**

**I acknowledge that my supervisor(s), in good faith, has offered and made**

**me an opportunity to seek necessary medical evaluation and/or treatment. At**

**at a later time, I understand that I may request from my supervisor(s) a medical**

**authorization to obtain medical evaluation and/or treatment for the above**

**described injury; which request can either be approved or denied.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employee’s Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Supervisor/HR Administrator Date**