DECLINATION OF MEDICAL TREATMENT

(This report is to be filled out by the employee)

Name of Injured: _____

Work Location: _____

Date of Injury: _____ Hour: _____ AM PM

EMPLOYEE COMMENT:

_____

_____

_____

_____

_____

_____

I have reported the injury to my supervisor and I decline medical treatment at this time.

I have been advised of the procedures for seeking medical treatment for my alleged work-related injury/illness. I acknowledge that my supervisor(s), in good faith, have offered and made available to me an opportunity to seek necessary medical treatment and/or observation. By signing below, I am choosing to decline medical treatment for the above referenced injury. I further understand that by declining medical treatment at this time, my employer, **will not** be responsible for any medical expenses or lost wages.

At a later time, I may request from my employer a medical authorization to obtain medical treatment and/or observation for the above described injury.

Date: _____ Employee Signature _____

Date: _____ Witness Signature _____