



REFUSAL OF MEDICAL TREATMENT OR OBSERVATION

Employee Name: _____ Date Reported: _____

Date of Incident: _____ Time of Injury: _____

Supervisor Name: _____ Location: _____

Witness(es) Name(s)

Description of Injury (What was injured and how severe was the injury)

Brief description of what was injured and how it happened.

I, hereby acknowledge my refusal of medical treatment and/or observation offered to me for the 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, have offered and made available to me an opportunity to seek necessary medical treatment and/or observation. 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

Employee Representative / Witness

Date

Manager Signature

Date