DynamicHR
Total Human Resource Administration

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 Part(s) 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 __________________ for the 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 supervisor(s), in good faith, have offered and made available to me an opportunity to seek necessary medical treatment and/or observation.

At a later time, I understand that I may request from my supervisor(s) a medical authorization to obtain medical treatment and/or observation for the above described injury; which request can then be either approved or denied. ____________________

______________________ ____________________
Employee's Signature Date

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