WORKERS' COMPENSATION REFUSAL OF TREATMENT

DATE: ____________

EMPLOYEE: _____________________

As of the above noted date, I am notifying _________________(agency) of an injury that occurred on(date)___________. This injury ☐ was; ☐ was not initially reported by me to my supervisor on (date)_____________.

This injury (briefly describe condition/body part) ___________________________________, did occur while I was employed with the _______________(agency), and while performing my assigned duties.

At this time I have been requested by a representative of _______________(agency) to be *medically evaluated* by a _______________(agency) preferred healthcare provider. However, I <u>decline</u> to be medically evaluated for the above noted condition. I understand that by signing this document any future claims regarding this injury will require a medical evaluation by the _______________(agency) healthcare provider listed below. I also understand that should I decide to seek medical treatment for this injury that I must immediately notify my supervisor and go to the below listed provider:

PROVIDER: ____

ADDRESS: ____

PHONE: (_____)_________________

(NOTE: SHOULD THE CONDITION BECOME LIFE THREATENING YOU SHOULD SEEK APPROPRIATE EMERGENCY MEDICAL CARE)

I ☐ have ☐ have not sought medical treatment for this injury from:

TREATING PHYSICIAN'S Phone Number: _________________
NAME/ADDRESS (including city & state)

____

____

STATEMENT: I have read the above information and it is a factual and true statement. I authorize any physician, hospital or healthcare provider to release and furnish any, and all, medical records or other information pertaining to the above listed condition.

_____________________________	_____________________________
Employee signature	**Supervisor/witness signature**
Date _____________	Date _______________