DECLINE OF MEDICAL TREATMENT OR OBSERVATION

Employee's Name: ______________________________ Date Reported: ___________________

Date of Injury: ________________________ Time of Injury: __________________________

Supervisor: __________________________________ Client/Location: _________________

Witness(es): ____

Nature of Injury/Condition: ____

Description of Injury (Body Part(s) Injured): ___________________________________

Brief Narrative Description of the Incident: ___________________________________

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I, hereby acknowledge my declination of medical treatment and/or observation offered to me by _____________________ for the injury or illness reported on ____________________. I recognize that signing this declination does not necessarily impact my later eligibility for Workers' Compensation benefits as subject to statue and insurer review.

At this time, I acknowledge that my supervisor/employer, in good faith, has offered and made available to me an opportunity to seek necessary medical treatment and/or observation.

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

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Employee's Signature

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Date

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Employee Representative/Witness