**WORK COMP REFUSAL OF MEDICAL TREATMENT OR OBSERVATION**

Employee's Name: _____ Date Reported:_____

Date of Injury:_____ Time of Injury:_____

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 Company 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.

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.

_____

Employee's Signature
Date:_____