Refusal of Medical Treatment or Observation
Workers' Compensation

Employee Name: _____

Date of Injury: _____ Time of Injury: _____

Date Reported: _____ Location of Incident: _____

Supervisor(s): _____

Witness(es): _____

Nature of Injury/Condition: _____

_____

_____

Description of Injury/Condition [Body Part(s) Injured]: _____

_____

_____

Brief Narrative/Description of Incident: _____

_____

_____

_____

I, [INSERT EMPLOYEE NAME], hereby acknowledge that my supervisor(s) has offered and made available to me an opportunity to seek necessary medical treatment and/or observation at the expense of my employer, , for the work-related injury I incurred on [INSERT DATE OF INJURY]. I am voluntarily choosing to decline medical treatment and/or observation at this time.

I understand that I may request from my employer, at a later time, authorization to obtain medical treatment and/or observation for the injury described above. However, I understand that my refusal of medical treatment and/or observation today may impact my eligibility for workers' compensation benefits related to the injury described above.

_____ _____

Employee Signature Date

_____ _____

Witness Date

DISCLAIMER FOR EMPLOYERS

Workers' compensation is regulated by state law and the validity and strength of this waiver may depend on local regulations. In addition, this waiver may not supersede an employer's obligation to report the injury for which the employee has refused treatment or observation to the applicable state regulatory agencies. Consult with your insurance carrier and/or legal counsel for a better understanding of the laws that govern your particular case and an accurate assessment of any legal liability under local workers' compensation laws.