



## 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 decline 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 \_\_\_\_\_