REFUSAL OF TREATMENT

Today's Date: _____

Team Member Name: _____

As of the date noted above, I am notifying my employer of an injury that occurred on

Date: _____

☐ My Supervisor did not receive notification of this incident.

☐ My Supervisor did receive notification of this incident on (date): _____

This injury, (briefly describe condition)

_____

_____

did occur during my normal scope and duties.

At this time, I have been requested by employer to be medically evaluated by a preferred medical 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 preferred healthcare provider listed below. I also understand that should I decide to seek medical treatment for this injury that I must first notify my supervisor and go to the following provider:

Provider: _____

Address: _____

Phone: _____

SHOULD THIS CONDITION BECOME LIFE THREATENING YOU SHOULD SEEK APPROPRIATE MEDICAL CARE.

Team Member Statements

By signing this form, I acknowledge:

I have not sought medical treatment for this injury.

I understand that it is the policy of my employer to have a post-accident drug screen and this refusal of medical treatment does not remove the requirement that I receive a post-accident drug screen.

I have read the above information and agree it is factual and a 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.

_____	_____
Team Member Signature	Supervisor / Witness Signature
_____	_____
Date	Date