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:

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 statute 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.

____
Employee's Signature

____
Date

____
Employee Representative/Witness