Refusal of Medical Treatment

Employee's name (please print)	**Employer's name:**
Date of injury:	**Date of treatment offer:**
Description of injury:	
Body part(s) injured:	

I have been advised by my employer that I may seek medical treatment for the event described above. I do not wish to seek medical attention at this time, but will advise my supervisor or employer immediately should I wish to see a medical provider.

I understand that my employer has the right to select a medical provider for examination or treatment for the first thirty days following this injury.

If I elect to seek medical treatment without advising my employer, or without obtaining authorization from my employer, I understand I may be responsible for the total cost of said treatment.

_____
Employee's signature

_____
Signature of employer's representative

_____
Name of employer's representative (please print)

_____
Date

_____
Date