REFUSAL OF MEDICAL TREATMENT

I have declined the offer of medical treatment for a _____
(describe)

Injury sustained on _____ at the following location _____
(date) *(location of accident)*

at this time.

_____
(Signature of Employee)

_____
(Date)

_____
(Signature of Supervisor)

_____
(Signature of Witness)

NOTE: This form does not waive the right to future medical treatment for this injury.

Should future medical attention be required for this injury, notify your immediate supervisor and request a "Worker's Compensation Claim" form. Your immediate supervisor will process this form.