Refusal of Medical Treatment

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

I have been advised by my employer that I may seek medical treatment for the illness or injury 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 or illness.

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