Workers' Compensation
STATE HUMAN RESOURCES

# WORKERS' COMPENSATION REFUSAL OF TREATMENT

DATE: _____

EMPLOYEE: _____

**As of the above noted date, I am notifying _____(agency) of an injury that occurred on(date)_____. This injury ☐ was; ☐ was not initially reported by me to my supervisor on (date)_____.**

**This injury (briefly describe condition/body part) _____, did occur while I was employed with the _____(agency), and while performing my assigned duties.**

**At this time I have been requested by a representative of _____(agency) to be *medically evaluated* by a _____(agency) preferred healthcare 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 _____(agency) healthcare provider listed below. I also understand that should I decide to seek medical treatment for this injury that I must immediately notify my supervisor and go to the below listed provider:**

**PROVIDER:** _____

**ADDRESS:** _____

**PHONE:** (_____)_____

*(NOTE: SHOULD THE CONDITION BECOME LIFE THREATENING YOU SHOULD SEEK APPROPRIATE EMERGENCY MEDICAL CARE)*

I ☐ have ☐ have not sought medical treatment for this injury from:

**TREATING PHYSICIAN'S Phone Number:** _____
**NAME/ADDRESS** (including city & state)
_____

_____

**STATEMENT: I have read the above information and it is a factual and 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.**

_____ _____

**Employee signature** **Supervisor/witness signature**

Date _____ Date _____