EMPLOYEE WAIVER OF MEDICAL TREATMENT

DATE: _____

EMPLOYEE NAME: _____

As of the date noted above, I am notifying my employer of an injury that occurred on

_____, 20___

- ❑ My supervisor did not receive notification of this incident.
- ❑ My supervisor did receive notification of this incident on _____, 20___

This injury, (briefly describe condition) _____

_____

occurred during the normal scope and duties of employment.

My employer has offered me medical treatment for the above noted condition. **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 through my employer's workers compensation or I may be responsible for any medical bills or lost wages. I also understand that should I seek treatment for this injury, I must first notify my supervisor.

SHOULD THE CONDITION BECOME LIFE THREATENING SEEK APPROPRIATE EMERGENCY CARE IMMEDIATELY

EMPLOYEE STATEMENTS

By signing this form, I acknowledge:

- I have not sought medical treatment for this injury
- I have read the above information and agree it is 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**