



WORKERS COMP REFUSAL OF MEDICAL TREATMENT OR OBSERVATION

Employee's Name: _____ Date Reported: _____

Date of Injury: _____ Time of Injury: _____

Supervisor: _____ Location: _____

Witness (es):

Nature of Injury / Condition:

Description of Injury [Body Part(s) Injured]:

Brief Narrative Description of the Incident:

I, hereby acknowledge my refusal of medical treatment and/or observation offered to me at the expense of the City of Belpre for the work-related injury I incurred on _____. By signing this form, I realize that I do not necessarily affect my later eligibility for workers' compensation.

I acknowledge that my supervisor(s), in good faith, have offered and made available to me an opportunity to seek necessary medical treatment and/or observation. I am aware that by declining medical treatment at this time. My employer will not be responsible for any medical expenses or lost wages.

At a later time, I may request from my employer, via my supervisor, a medical authorization to obtain medical treatment and/or observation for the above-described injury. **Is your Tetanus Shot Up to Date: YES or NO**

Employee's Signature

Guardian's Signature (if under 18 years old)

Date

Guardians Printed Name

Employee Supervisor/Representative

Date