DECLINE OF MEDICAL TREATMENT FORM

This form is only to be signed if you do not require medical attention in relation to your report of an on the job incident.

I, _____, acknowledge that I have reported an on the job incident that occurred on (date)_____ The facility has offered me medical attention to be administered by the facility's designated workers' compensation physician. However, at this time I feel I do not require medical attention and by signing this form I am stating that I can safely complete the essential functions of my job without compromising the safety of my coworkers, residents, or myself. I understand that if my condition changes in relation to this work related incident that I must notify the facility's administrator before seeking any medical attention.

By signing this form I am declining medical attention by a physician at this time.

Employee_____Date_____

Supervisor_____Date_____