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

_____ , 201__

- ❑ My supervisor did not receive notification of this incident.
- ❑ My supervisor did receive notification of this incident on _____, 201__

This injury, (briefly describe condition) _____

_____

occurred during the normal scope and duties of employment.

At this time, I have been requested by my employer to be medically evaluated by a *preferred medical provider within the managed care network.* **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 a preferred medical provider within the managed care network 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 and go to a provider in the managed care network.

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 understand that it is the policy of my employer to have a post-accident drug screen and this refusal of medical treatment does not remove the requirement that I receive a post-accident drug screen.
- 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**