# Medical Waiver Form for Work

**Employee Name:** ___________________________________________

**Employee ID:** _________________________

**Department:** ______________________________________________

**Job Title:** ________________________________________________

**Work Email:** ______________________________________________

**Phone Number:** ____________________________________________

**Medical Disclosure (Please describe any relevant medical conditions):**

**Table of Medical Restrictions**

| Activity | Restriction | Duration | Additional Notes |
|---|---|---|---|
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## Consent to Medical Treatment:

**I consent to receive emergency medical treatment necessary while at the workplace. This waiver does not preclude me from asserting a claim under workers' compensation laws.**

**Employee Signature: __________________________ Date: _______________**

**HR Representative Signature: ___________________ Date: _______________**

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