employer solutions staffing group

Leveraging Resources in a Changing Market

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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 on the job incident. 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 co-workers, 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