



REFUSAL OF MEDICAL TREATMENT FOR A WORK RELATED INJURY

I have been advised to seek and understand that medical attention is available for my work related injury from my supervisor. I am hereby declining to go to the clinic and/or doctor as advised by my supervisor. I understand that I may seek medical attention at a later time if deemed necessary.

Employee Name: _____

Date of Injury: _____

Employee Signature _____ Date _____

Supervisors Name _____

Phone Number _____

Supervisors Signature _____ Date _____

HR Signature _____ Date _____

Fax form to:
FAX # 941-487-5021
Attention: Ron Hambrick

