Refusal of Medical Treatment or Observation Form

Purpose: This form documents an employee's voluntary refusal of medical treatment or observation following a work-related injury or incident, in compliance with workers' compensation laws. It protects both the employee and employer by recording the decision without affecting future eligibility for benefits.

Instructions: Complete immediately after offering treatment. Employee and witness must sign. Submit to hr@abetterchoicestaffing.com and file with incident records. If injury is recordable, log on OSHA Form 300.

Employee's Name: _____ Date Reported: _____

DOB: _____ Social Security Number: _____

Address: _____

Date of Injury: _____ Time of Injury: _____

Supervisor: _____ Client / Location: _____

Witness(es): _____

Nature of Injury/Condition: _____

Description of Injury [Body Part(s) Injured]:

_____

Brief Narrative Description of the Incident:

_____

I hereby acknowledge my refusal of medical treatment and/or observation offered to me at the expense of my employer for the work-related injury I incurred on _____. By signing this form, I realize that I do not necessarily affect my later eligibility for Workers' Compensation.

I acknowledge that my supervisor(s), in good faith, have offered and made available to me an opportunity to seek necessary medical treatment and/or observation. I am aware that by declining medical treatment at this time, my employer will not be responsible for any medical expenses or lost wages.

At a later time, I may request from my employer, via my supervisor, a medical authorization to obtain medical treatment and/or observation for the above described injury.

Employee's Signature: _____

Date: _____

Employee Representative/Witness: _____