Work Place Injury Refusal of Treatment

Client Name _____

Employee Name _____

Date of Injury _____

Description of Accident _____

_____

_____

To be completed by employee

Reason I am declining medical treatment: _____

_____

_____

_____

I understand that medical treatment is available to me paid for by Choice Employer Solutions (employer) for the accident described above. I confirm that _____ offered me this medical treatment on _____ for this work related accident. By my own choice, I have decided NOT to seek medical treatment for this injury. Should I seek medical treatment at a later date for this work related injury, I must first contact my employer and receive authorization PRIOR to being treated. I also understand that to receive this employer paid medical treatment for this injury, I must go to the approved medical provider that my employer provides and also complete all necessary paperwork for an authorization from my employer. Any treatment I receive before an authorization has been granted will result in non-payment by my employer.

_____ _____

Employee Printed Name Date

_____ _____

Employee Signature Date

_____ _____

Signature of Witness Date