DECLINATION OF MEDICAL EXAMINATION/TREATMENT

EMPLOYEE INFORMATION

Name of Employee_____

Employer_____

Date of Incident/Accident _____ / _____ /_____Time of Incident/Accident _____

Description of Incident/Accident_____

_____

_____

DECLINATION ACCEPTANCE

Please initial the appropriate paragraph

_____ My signature below confirms that I AM NOT experiencing any signs or symptoms resulting from the incident/accident described above. Medical treatment has been offered to me; however, I decline any medical evaluation or treatment as a result of this job-related incident/accident.

_____ My signature below confirms that I AM experiencing signs or symptoms resulting from the incident/accident described above. Medical treatment has been offered to me; however, as I feel my symptoms are improving, I decline any medical evaluation or treatment as a result of this job-related incident/accident.

If the need for medical treatment arises as a result of this incident/accident, I have been instructed to inform my supervisor immediately.

_____ _____
Signature of Employee Date

_____ _____
Signature of Employer Date

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