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 info@rsdstaffing.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