WAIVER OF TREATMENT

OF

WORK RELATED INJURY

I, _____, decline to seek meical treatment for an incident that I reported as havig occurred during the course and scope of my employment on _____.

The Mount Vernon City School District has provided me a Work Related Injuries Form for which injured emloyees must complete for work related injuries requiring medical attention.

I agree to notify my employer immediately should I choose to seek medical attention at a later date. I understand that treatment must be with the authorized medical provider.

Acknowledgement

I, _____, have read and understand the above paragraphs.

_____	_____	_____
Supervisor's Name (Print)	Supervisor's Signature	Date
_____	_____	_____
Witness Name (Print)	Witness SIgnature	Date

_____

Employee Signature Date