Employee Refusal of Medical Treatment Form Work Injury

DATE OF INJURY: _____ **CAMPUS NAME:** _____

EMPLOYEE NAME: _____

BRIEF DESCRIPTION OF INJURY:

_____

_____

I have been advised by my Principal/Human Resources of the procedure for seeking medical treatment for my work-related injury/illness and right to file a worker's compensation claim with Texas Mutual for my injury.
By signing below, I am choosing to decline to seek medical care for the above referenced injury. I understand if I decide to seek medical care at a later date, I must IMMEDIATELY contact the Principal and Human Resources at 512-869-3020 for further instructions before contacting a doctor.

EMPLOYEE SIGNATURE: _____ **DATE:**_____

PRINCIPAL SIGNATURE: _____**DATE**: _____

Principal/Human Resources note:

Use this form if an employee has a minor injury and they do not feel that they need medical treatment. If the employee's injury is obvious and needs immediate care please get medical attention and/or call 911, as soon as possible.

Reminder to complete an Accident/Incident report form as soon as possible. Please go to www.orendaeducation.org under Employee Tools to find the "Employee Work Injury" form.

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