WAIVER OF TREATMENT
OF
WORK RELATED INJURY

I,_____decline to seek medical treatment for an incident that I reported as having occurred during the course and scope of my employment on _____. My Employer has provided me with the Workers' Compensation provider for which injured employees must see treatment 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.

ACKNOWLEDGMENT

I,_____have read and understand the above paragraphs.

Employee's Name (Print)	(Employee's Signature)	Date
Supervisor's Name (Print)	(Supervisor's Signature)	Date
Witness Name (Print)	(Witness Signature)	Date