BARTLETT CITY SCHOOLS

HUMAN RESOURCES DEPARTMENT

WORKER'S COMPENSATION REFUSAL OF MEDICAL TREATMENT OR OBSERVATION

Employee's Name: _____ Date of Injury: _____

Supervisor: _____ Location: _____

I, hereby acknowledge my refusal of medical treatment and/or observation offered to me at the expense of Bartlett City Schools 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, that Bartlett City Schools, will not be responsible for any medical expenses or lost wages.

I am aware that I may request from Bartlett City Schools, via my supervisor, a medical authorization to obtain medical treatment and/or observation for the above described injury at a later time.

_____ _____

Employee's Signature Date

_____

Employee Representative/ Witness