

**Refusal of Medical Treatment or Observation  
Forsyth County Schools Workers' Compensation**

Employee Name: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_

Date Reported: \_\_\_\_\_

Location of Incident \_\_\_\_\_

Supervisor(s): \_\_\_\_\_

Witness(es): \_\_\_\_\_

I, \_\_\_\_\_, hereby acknowledge that my supervisor(s) has offered and made available to me an opportunity to seek necessary medical treatment and/or observation at the expense of my employer, Forsyth County Schools (FCS), for the work-related injury I incurred on \_\_\_\_\_ (Date). I am voluntarily choosing to decline medical treatment and/or observation at this time.

I understand that I may request from my employer, at a later time, authorization to obtain medical treatment and/or observation for the injury described above. However, I understand that my refusal of medical treatment and/or observation today may impact my eligibility for workers' compensation benefits related to the injury described above. If I do decide at a later time to seek medical treatment, I understand that I must let FCS know and if treatment is authorized, I must treat from a physician located on our posted panel of physicians.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

- This form requires two signatures before submitting. The witness may have not been witness to the injury being reported, but a witness to the signing of the refusal of medical treatment that was offered.