Decline of Medical Treatment Form

This form is only to be signed if you **do not** require medical attention in relation to your report of an on-the-job incident.

I, _____acknowledge that I have reported an on-the-job incident. The facility has offered me medical attention to be administered by the facility's designated workers' compensation physician. However, at this time I feel **I do not require** medical attention and by signing this form I am stating that I can safely complete the essential functions of my job without compromising the safety of my co-workers, residents, or myself. I understand that if my condition changes in relation to this work-related incident I must notify the facility administrator **before** seeking any medical attention.

By signing this form, I am declining medical attention by a physician at this time.

Employee	**Date**	**Supervisor**	**Date**

Updated 2/11/25