WORKERS' COMPENSATION REFUSAL OF TREATMENT

DATE: ____________

EMPLOYEE: _____________________

As of the above noted date, I am notifying ________________(agency) of an injury that occurred on(date)__________. This injury ☐ was; ☐ was not initially reported by me to my supervisor on (date)____________.

This injury (briefly describe condition/body part) ________________________________, did occur while I was employed with the ______________(agency), and while performing my assigned duties.

At this time I have been requested by a representative of ______________(agency) to be *medically evaluated* by a ______________(agency) preferred healthcare provider. However, I <u>decline</u> to be medically evaluated for the above noted condition. I understand that by signing this document any future claims regarding this injury will require a medical evaluation by the ______________(agency) healthcare provider listed below. I also understand that should I decide to seek medical treatment for this injury that I must immediately notify my supervisor and go to the below listed provider:

PROVIDER: Cape Fear Valley Medical Center

ADDRESS: 1638 Owen Drive Fayetteville, NC 28304

PHONE: (910) 615-4000

(NOTE: SHOULD THE CONDITION BECOME LIFE THREATENING YOU SHOULD SEEK APPROPRIATE EMERGENCY MEDICAL CARE)

I ☐ have ☐ have not sought medical treatment for this injury from:

TREATING PHYSICIAN'S Phone Number: ________________
NAME/ADDRESS (including city & state)

____

____

STATEMENT: I have read the above information and it is a factual and true statement. I authorize any physician, hospital or healthcare provider to release and furnish any, and all, medical records or other information pertaining to the above listed condition.

______________________________ ______________________________

Employee signature **Supervisor/witness signature**

Date _____________ Date ______________