Office of State Human Resources

ROY COOPER
Governor

BARBARA GIBSON
Director, State Human Resources

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 decline 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: _____

ADDRESS: _____

PHONE: (_____)_____

(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 _____