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WORKERS' COMPENSATION MEDICAL TREATMENT WAIVER FORM

I decline to seek medical treatment for an incident that I reported as having occurred during the course and scope of my employment on _____.

My employer has provided me with their Workers' Compensation panel provider list from which injured employees must seek treatment for work related injuries requiring medical attention for a period of 90 days from the date of first visit.

I agree to notify my employer immediately should I choose to seek medical attention at a later date.

Employee Name: _____
Print Name

Employee Signature: _____ Date: _____
Signature

Employer: _____
Print

Witness Name: _____
Print Full Name

Witness Signature: _____ Date: _____
Signature

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