**WORK COMP REFUSAL OF MEDICAL TREATMENT WITH CONSENT TO DRUG TESTING**

Employee's Name: Date Reported:

Date of Injury: Time of Injury:

Supervisor: Client / Location:

Witness(es):

Nature of Injury/Condition:

Description of Injury [Body Part(s) Injured]:

Brief Narrative Description of the Incident:

I, hereby acknowledge my refusal of medical treatment and/or observation offered to me at the expense of (insured name) for the work-related injury I incurred on (date of injury). By signing this form, I realize that I do not necessarily affect my later eligibility for Workers' Compensation.

I acknowledge that my supervisor(s) , in good faith, have offered and made available to me an opportunity to seek necessary medical treatment and/or observation. I am aware that by declining medical treatment at this time my employer will not be responsible for any medical expenses or lost wages.

It is also my understanding that this is a Drug Free Workplace, and a mandatory drug screening after a work-related accident is required. At a later time, I may request from my employer, via my supervisor, authorization to obtain medical treatment and/or observation for the above described injury.

Employee's Signature Employee Representative/Witness

Date Date

**REFUSAL TO CONSENT TO A DRUG TEST**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, refuse to submit for mandatory drug testing/screening.

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(Print Name) (Signature) (Date)

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(Witness Print Name) (Witness Signature) (Date)

C: USIS/FRSA-SIF Claims Adjuster

File

Sent via certified and regular mail