AdvancedHR

Your Advanced Business Partner

REFUSAL OF DOCTOR'S CARE AGREEMENT

_____

Name of Advanced's Client Employing Injured Worker

COMPLETE ALL BLANKS

I, _____ , have reported a job related injury on_____/_____/_____.
(Print Name of Employee) (Injury Date)

I have explained the details of this incident to my supervisor, but do not wish to seek any outside medical treatment this time.

I understand that by signing this statement, I am not giving up my right to seek medical treatment in the future, if I feel it is necessary. I further understand that if I do not follow the procedures as re□ected in my employment agreement, my injury may not be covered by Workers' Compensation.

I understand that state law allows an employer to require a drug screen within twenty-four hours of an injury report, and by not complying with that law, I may not be covered by Workers' Compensation for this injury.

Understood and agreed on _____/_____/_____,
(Today's Date)

By: _____
(Signature of Employee)

SS #: _____

Date of Injury: _____/_____/_____.

******DUE WITHIN 24 HOURS OF ACCIDENT******