ACCESS SERVICES INC.

WORK COMP REFUSAL OF MEDICAL TREATMENT OR OBSERVATION

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 Access Services, Inc. for the work-related injury I incurred on _____By signing this form, I understand that this decision does not necessarily affect my eligibility for Worker's Compensation in the future.

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 now, my employer will not be responsible for any medical expenses or lost wages related to this injury.

At a later time, I may request from my employer, via my supervisor, a medical authorization to obtain medical treatment and/or observation for the above-described injury.

Employee's Signature: _____

Date: _____

Employer Witness: _____

Date: _____