Refusal of Medical Treatment for Injury

Date: _____ Employee Number: _____

First Name: _____ Last Name: _____

Home Address: _____ City: _____ Zip: _____

I have reported an injury to_____ on _____, and I am

refusing medical treatment at this time. I understand it is mandatory that I complete an Employee's Report of Injury and return the completed form to my immediate supervisor, or the Business Office. I have received an Authority for Treatment form and understand that I may go to any emergency room, or the following facility listed below for the first ten consecutive days after injury.

Henry Ford Macomb Health Center-Urgent Care
80650 Van Dyke Rd
Bruce Twp, MI 48065
(810) 798-6410
Hours: Mon-Fri 8:00 a.m. – 8:00 p.m.
Sat & Sun 9:00 a.m. – 5:00 p.m.

By signing this form, I am refusing medical treatment for my injury. If I choose to seek medical treatment, I understand I must abide by the policy stated above. I further understand that my injury is not considered work-related until approved by the worker's compensation carrier.

_____ _____

Employee's Name Date

_____ _____

Supervisor's Name Date