**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

Romeo, MI 48446

(810) 798-6410

Hours: Mon-Fri 8:00 a.m. – 10:00 p.m.

Sat & Sun 10:00 a.m. – 6:00 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