REFUSAL OF MEDICAL TREATMENT

DATE: ______________________________________________________

EMPLOYEE NAME: ______________________________________________________

INCIDENT DATE: ______________________________________________________

INJURY: ______________________________________________________

I have been advised of the procedures for seeking medical treatment for my alleged work-related injury/illness. By signing below, I am choosing to refuse medical treatment for the above referenced injury. I understand that my signature indicates my refusal of the medical treatment that has been offered to me and that I am completely responsible for seeking medical attention on my own and will pay for any subsequent bills associated with this medical treatment. I further understand that my signature on this refusal form may result in loss of benefits under the NC Workers’ Compensation Act.

Employee Signature: ___________________________ Date: ______________

Supervisor Signature: ___________________________ Date: ______________

WCA Signature: ___________________________ Date: ______________