Refusal of Medical Treatment or Observation Form

I, _____(print name), hereby acknowledge my refusal of medical treatment and/or observation offered to me by Pacesetter Health's Worker's Compensation, for the work-related incident that occurred on _____(date of injury). 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.

At a later time, I understand that I may request a medical evaluation for the above described injury. By signing this form, I acknowledge any future claims regarding this incident will require a medical evaluation through an approved medical provider. I also realize should I decide to seek medical treatment on my own for the incident described above, I must immediately notify my supervisor and Human Resources. I understand that currently refusing treatment does not necessarily affect my later eligibility for Worker's Compensation.

Note: Should the condition become life threatening you should seek appropriate emergency medical care.

_____ _____

Employee Signature Date

_____ _____

Witness/Supervisor Signature Date