ARCHDIOCESE of BALTIMORE

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WORK COMP REFUSAL OF MEDICAL TREATMENT OR OBSERVATION

Employee's Name: _____ Date Reported: _____
Date of Injury: _____ Time of Injury: _____
Supervisor: _____ 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 ARCHDIOCESE OF BALTIMORE for the work-related injury I incurred on _____. By signing this form, I realize that I do not necessarily affect my later eligibility for Workers' Compensation.

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 at this time, that my employer, will not be responsible for any medical expenses or lost wages.

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

_____
Employee Representative/Witness