WORKERS' COMPENSATION
WAIVER OF MEDICAL TREATMENT OR OBSERVATION FORM

Employee Name: _____

Location: _____

Today's Date: _____

Brief Description of Injury: _____

_____

I, _____, hereby acknowledge my refusal of medical treatment and/or observation offered to me at the expense of Plymouth Community School Corporation for the work-related injury I incurred on _____.

By signing this form, I realize that it does not necessarily effect my later eligibility for Workers' Compensation.

I acknowledge that my supervisor(s), in good faith, has 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 from my supervisor(s) a medical authorization to obtain medical treatment and/or observation for the above described injury; which request can then be either approved or denied.

_____
Employee Signature

_____
Supervisor Signature

Rec'd in Admin Office: