REFUSAL OF MEDICAL TREATMENT

Today's date _____ Last four digits SS# _____

PRINT CLEARLY - employee name _____

Work site _____ Employee title _____ Mobile number/other _____

Date of injury (DOI) _____ Date District noticed _____ Date treatment offer _____

Body part(s) injured _____

Description of injured: _____

I have been advised by the *Paso Robles Joint Unified School District* that I may seek medical treatment for the event described above. **I DO NOT** wish to seek medical attention at this time, but will advise my supervisor or employer immediately should I wish to see a medical provider.

I understand that my employer has the right to select a medical provider for examination or treatment for the first thirty days following this injury.

If I elect to seek medical treatment without advising my employer, or without obtaining authorization from my employer, I understand I may be responsible for the total cost of said treatment.

Employee's Signature _____ **Date** _____

PRINT name of employer's representative/site supervisor _____

SIGNATURE of employer's representative/site supervisor _____ Date _____