Worker's Compensation Refusal of Medical Treatment or Observation Form

Employee's Name (Print):_____

Department:_____ Supervisor:_____

Description of incident and injury (list Body Part(s) involved):_____
_____
_____
_____
_____

I, _____, hereby acknowledge my refusal of medical treatment and/or observation offered to me by East Carolina University's Worker's Compensation program (ECU 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 ECU Worker's Compensation 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 the ECU Worker's Compensation Manger. 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