MEDICAL TREATMENT / DRUG TESTING REFUSAL FORM

Date: ____________________________

Employee: _____________________________________ Social Security # : _______________________

Employer: ____

Date of Accident: _______________________________ Time of Accident: _______________________

Location Accident Occurred: ____

Description of Accident: ____

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(✓) CHECK ALL APPLICABLE

_____ I admit that I was involved in the above-listed accident and acknowledge that my employer has offered to provide me with medical treatment by my choice of physician at their cost. However, I have refused any medical treatment in relation to this accident. I understand that my refusal to submit to a medical examination or treatment may suspend any rights I may have to workers' compensation benefits.

Employee Signature: ____ Date: __________________

Print Name: ____

_____ I acknowledge that my employer has requested that I submit to a post accident drug/alcohol test pursuant to their written and promulgated substance abuse policy. I further acknowledge that I have refused to submit to a post accident drug test. I understand that, as a result of my refusal to submit to this test, it may be presumed that I was intoxicated at the time of this accident pursuant to any applicable laws and that this refusal may result in denial and/or forfeiture of any and all workers' compensation benefits.

Employee Signature: ____ Date: __________________

Print Name: ____

_____ The above employee has refused medical treatment and/or a post accident drug/alcohol test requested by his employer. The employee has been requested to sign this form and has refused. This form was read to the employee and he/she has acknowledged their understanding of this form.

Supervisor Signature: ____ Date: __________________

Print Name: ____

Witness Signature: ____ Date: __________________

Print Name: ____