REFUSAL OF MEDICAL TREATMENT

DATE: _____

EMPLOYEE NAME: _____

INCIDENT DATE: _____

INJURY: _____

I have been advised of the procedures for seeking medical treatment for my alleged work-related injury/illness. By signing below, I am choosing to refuse medical treatment for the above referenced injury. I understand that my signature indicates my refusal of the medical treatment that has been offered to me and I am completely responsible for any medical attention I seek on my own and will pay for any subsequent bills associated with this medical treatment. I further understand that my signature on this refusal form could result in loss of benefits under the AL Worker's Compensation Act.

_____ _____

Employee Signature Date

_____ _____

Supervisor/Management Signature Date