WORKERS' COMPENSATION REFUSAL OF TREATMENT

DATE: ____________

EMPLOYEE: _____________________

As of the above noted date, I am notifying Caldwell County Schools of an injury that occurred on(date)___________. This injury ☐ was; ☐ was not initially reported by me to my supervisor on (date)_____________.

This injury (briefly describe condition/body part) ___________________________________, did occur while I was employed with Caldwell County Schools, and while performing my assigned duties.

At this time I have been requested by a representative of Caldwell County Schools to be *medically evaluated* by a Caldwell Heath Works a preferred healthcare provider. However, I decline to be medically evaluated for the above noted condition. I understand that by signing this document any future claims regarding this injury will require a medical evaluation by Caldwell Health Works the healthcare provider listed below. I also understand that should I decide to seek medical treatment for this injury that I must immediately notify my supervisor and the Education Center (Human Resources Department) for an appointment with the provider listed below:

PROVIDER: Caldwell Health Works

ADDRESS: 270 Pine Mountain Road Hudson, NC 28638

PHONE: (828) 757-8272_

(NOTE: SHOULD THE CONDITION BECOME LIFE THREATENING YOU SHOULD SEEK APPROPRIATE EMERGENCY MEDICAL CARE)

I ☐ have ☐ have not sought medical treatment for this injury from:

TREATING PHYSICIAN'S Phone Number: __________________
NAME/ADDRESS (including city & state)

STATEMENT: I have read the above information and it is a factual and true statement. I authorize any physician, hospital or healthcare provider to release and furnish any, and all, medical records or other information pertaining to the above listed condition.

_________________________________   _________________________________

Employee signature   **Supervisor/witness signature**

Date ______________   Date ________________