FORSYTH COUNTY SCHOOLS
Quality Learning and Superior Performance for All

Refusal of Medical Treatment or Observation
Forsyth County Schools Workers' Compensation

Employee Name: _____

Date of Injury: _____ Time of Injury: _____

Date Reported: _____

Location of Incident _____

Supervisor(s): _____

Witness(es): _____

I, _____, hereby acknowledge that my supervisor(s) has offered and made available to me an opportunity to seek necessary medical treatment and/or observation at the expense of my employer, Forsyth County Schools (FCS), for the work-related injury I incurred on _____ (Date). I am voluntarily choosing to decline medical treatment and/or observation at this time.

I understand that I may request from my employer, at a later time, authorization to obtain medical treatment and/or observation for the injury described above. However, I understand that my refusal of medical treatment and/or observation today may impact my eligibility for workers' compensation benefits related to the injury described above. If I do decide at a later time to seek medical treatment, I understand that I must let FCS know and if treatment is authorized, I must treat from a physician located on our posted panel of physicians.

_____ _____
Employee Signature Date

_____ _____
Witness Date