



Norfolk Public Schools
NATIONALLY RECOGNIZED. GLOBALLY COMPETITIVE.

**WORKERS' COMPENSATION
REFUSAL OF MEDICAL TREATMENT OR OBSERVATION
FORM**

Employee's Name (Print): _____

Work Location: _____ **Supervisor:** _____

Witness(es): _____

Nature of Injury/Condition: _____

Description of Injury [Body Part(s) Injured]: _____

Brief Narrative Description of the Incident:

I, _____, hereby acknowledge my refusal of medical treatment and/or observation offered to me at the expense of Norfolk Public Schools for the work-related injury I incurred on (date) _____. By signing this form, I realize that I do not necessarily affect my later eligibility for Workers' Compensation. 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 from my supervisor(s) a medical authorization to obtain medical treatment and/or observation for the above described injury; which request can then be either approved or denied.

Employee's Signature

Date