WASHITA VALLEY COMMUNITY ACTION COUNCIL

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 that I am completely responsible for seeking medical attention 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 may result in loss of benefits under the Oklahoma Workers' Compensation Act.

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Safety Coordinator Signature: _____ Date: _____

Executive Director Signature: _____ Date: _____