DECLINATION OF MEDICAL EXAMINATION/TREATMENT

EMPLOYEE INFORMATION

Name of Employee _____

Employer _____

Date of Incident/Accident ____ / ____ / _____ Time of Incident/Accident _____

Description of Incident/Accident _____

_____

_____

TREATMENT DECLINATION

Please initial the appropriate paragraph

____ My signature below confirms that **I AM NOT** experiencing any signs or symptoms resulting from the incident/accident described above. Medical treatment has been offered to me; however, I decline any medical evaluation or treatment as a result of this job-related incident/accident.

____ My signature below confirms that **I AM** experiencing signs or symptoms resulting from the incident/accident described above. Medical treatment has been offered to me; however, as I feel my symptoms are improving, I decline any medical evaluation or treatment as a result of this job-related incident/accident.

If the need for medical treatment arises as a result of this incident/accident, I have been instructed to inform my supervisor immediately.

I understand that I may be subject to post-accident or reasonable cause alcohol/drug testing pursuant to Rule 12 in the Rules and Regulations of the Personnel Board of Houston County.

Signature of Employee _____ Date _____

Signature of Supervisor _____ Date _____

Accident Investigation form completed by: _____ _____
Signature of Supervisor Completing Form Date