REFUSAL OF TREATMENT

DATE: _____

EMPLOYEE NAME: _____

As of the date noted above, I am notifying my employer (Wayne County) of an injury that occurred on:

_____, 20___.

This injury, (briefly describe)

_____

_____

did occur during my normal scope of duties.

At this time, I have been requested by my employer to be medically evaluated by a preferred medical 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 the preferred healthcare provider listed below. I also understand that should I decide to seek medical treatment for this injury that I must first notify the Loss Control Manager and go to the following provider:

Provider: **NOW Clinic**
3727 Friendsville Rd.
Wooster, OH 44691

EMPLOYEE STATEMENTS

By signing this form, I acknowledge that I have not sought medical treatment for this injury. I understand that it is the policy of Wayne County to have a post-accident drug screen and this refusal of medical treatment does not remove the requirement that I receive a post-accident drug test.

I have read and understood the above information and agree it is 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 condition.

Employee Signature _____ **Date** _____

Supervisor / Witness _____**Date** _____