

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):	
and made available to me an opportunity to se the expense of my employer, Forsyth County S	, hereby acknowledge that my supervisor(s) has offered ek necessary medical treatment and/or observation at chools (FCS), for the work-related injury I incurred on decline medical treatment and/or observation at this
treatment and/or observation for the injury des medical treatment and/or observation today ma benefits related to the injury described above.	oyer, at a later time, authorization to obtain medical scribed above. However, I understand that my refusal of ay impact my eligibility for workers' compensation If I do decide at a later time to seek medical treatment, eatment is authorized, I must treat from a physician
Employee Signature	Date
Witness	Date