



## NCDOT WORKERS' COMP REFUSAL OF TREATMENT

DATE: \_\_\_\_\_

EMPLOYEE: \_\_\_\_\_

As of the above noted date I am notifying NCDOT of an injury that occurred on \_\_\_\_\_ . This injury  was;  was not initially reported by me to my supervisor on \_\_\_\_\_ .

This injury, (briefly describe condition)

\_\_\_\_\_, did occur while I was employed with the NCDOT, and while performing my assigned duties.

At this time I have been requested by a representative of NCDOT to be *medically evaluated* by a NCDOT preferred healthcare 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 NCDOT healthcare provider listed below. I also understand that should I decide to seek medical treatment for this injury that I must immediately notify my supervisor and go to the below listed provider:

PROVIDER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

(NOTE: SHOULD THE CONDITION BECOME LIFE THREATENING YOU SHOULD SEEK APPROPRIATE EMERGENCY MEDICAL CARE)

I  have  have not sought medical treatment for this injury from:

TREATING PHYSICIAN'S NAME/ADDRESS \_\_\_\_\_

(including City and State) \_\_\_\_\_

**STATEMENT:** I have read the above information and it is a 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 listed condition.

\_\_\_\_\_  
Employee signature

\_\_\_\_\_  
Supervisor/witness signature

Date \_\_\_\_\_

Date \_\_\_\_\_