REFUSAL OF MEDICAL TREATMENT OR OBSERVATION

Name of Employee: _____ Date injury reported_____

Supervisor of Employee: _____

Nature of Injury / Medical Condition and location injury occurred on property:

_____
_____
_____
_____
_____

Date Injury Occurred: _____

Witness (es):

_____
_____

I, hereby acknowledge my refusal of medical treatment and/or observation offered to me at the expense of SUNY System Administration for the work-related injury I incurred on _____/ ____ / _____. By signing this form, I realize that I do not necessarily affect my later eligibility for Workers' Compensation.

I acknowledge that my supervisor(s), in good faith, have offered and made available to me an opportunity to seek necessary medical treatment and/or observation. I am aware that by declining medical treatment at this time, that my employer, will not be responsible for any medical expenses or lost wages.

At a later time, I may request from my employer, via my supervisor, a medical authorization to obtain medical treatment and/or observation for the above described injury.

_____
Employee's Signature

_____
Date

_____
Employee Representative/Witness