NORTH ORANGE COUNTY
COMMUNITY COLLEGE DISTRICT

Refusal of Medical Treatment Form

Employee's name (please print)	Employer's Rep/Supervisor's name:
Date of injury:	Date of treatment offer:
Description of injury:	
Body part(s) injured:	

I have been advised by my employer that I may seek medical treatment for the event described above. I do not wish to seek medical attention at this time, but I will advise my supervisor or employer immediately should I wish to see a medical provider.

If I elect to seek medical treatment without advising my employer, or without obtaining authorization from my employer, I understand I may be responsible for the total cost of said treatment.

_____ _____

Employee's signature Employer's Rep/Supervisor's Signature

_____ _____

Date Date