STAR HR

REFUSAL OF DOCTOR'S CARE AGREEMENT

COMPLETE ALL BLANKS

_____

Name of STAR HR's Client Employing Injured Worker

I, _____ , have reported a job related injury on _____/_____/_____ .
(Print Name of Employee) *(Injury Date)*

I have explained the details of this incident to my supervisor, but do not wish to seek any outside medical treatment this time.

I understand that by signing this statement, I am not giving up my right to seek medical treatment in the future, if I feel it is necessary. I further understand that if I do not follow the procedures as reflected in my employment agreement, my injury may not be covered by Workers' Compensation.

I understand that state law allows an employer to require a drug screen within twenty-four hours of an injury report, and by not complying with that law, I may not be covered by Workers' Compensation for this injury.

Understood and agreed on _____/_____/_____,
(Today's Date)

By: _____
(Signature of Employee)

SS #: _____

Date of Injury: _____/_____/_____.

****DUE WITHIN 24 HOURS OF ACCIDENT****