REFUSAL OF DOCTOR'S CARE AGREEMENT

COMPLETE ALL BLANKS

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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******

Star HR 618 E South Street Suite 660 Orlando FL 32801