

VOLUNTARY REFUSAL OF MEDICAL TREATMENT

Employee Name: _____ SS#: _____

Date of Injury: _____

I hereby acknowledge that I have suffered an on-the-job injury for which I do not require any outside professional medical attention. Pursuant to Florida Law, my employer has offered post-injury medical treatment to me and I have voluntarily chosen not to get such treatment.

Date

Employee Signature

Supervisor's Name

Supervisor's Signature