ESCAMBIA COUNTY RISK MANAGEMENT
WORKERS' COMPENSATION

NOTICE OF REFUSAL FOR MEDICAL TREATMENT

I _____, WITHOUT COERSION OR ADVICE AM REFUSING MEDICAL TREATMENT FOR AN ON-THE-JOB INJURY/ACCIDENT.

I UNDERSTAND I HAVE THIRTY (30) DAYS TO SEEK MEDICAL TREATMENT FOR THIS INJURY/ACCIDENT AS PER FLORIDA WORKERS' COMPENSATION STATUTE.

I UNDERSTAND I MUST CONTACT THE INSURANCE ADJUSTER ASSIGNED TO MY CLAIM PRIOR TO OBTAINING MEDICAL TREATMENT.

DATE OF INJURY/ACCIDENT: _____

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

SUPERVISOR'S SIGNATURE: _____