WORKERS' COMPENSATION
REFUSAL OF MEDICAL TREATMENT OR OBSERVATION

Employee's Name: _____

Work Location: Supervisor: _____

Witness(es): _____

Nature of Injury/Condition: _____

Description of Injury [Body Part(s) Injured]: _____
_____

Brief Narrative Description of the Incident:
_____
_____

I, _____, hereby acknowledge my refusal of medical treatment and/or observation offered to me at the expense of Kleen1, LLC., for the work-related injury I incurred on *(date)*_____. By signing this form, I realize that I do not necessarily affect my later eligibility for Workers' Compensation.

I acknowledge that my supervisor(s), in good faith, have offered and made available to me an opportunity to seek necessary medical treatment and/or observation. At a later time, I understand that I may request from my supervisor(s) a medical authorization to obtain medical treatment and/or observation for the above described injury; which request can then be either approved or denied.

_____ _____
Employee's Signature Date

_____
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