MEDICAL DECLINATION WAIVER

Service Sanitation

Employee Name: _____

Social Security Number (last 4)**:** _____

Date of Incident/Accident: _____ **Date Reported:** _____

Description of Incident/Accident: _____

_____

_____

Comprehensive Care Clinic Information

7501 West 15th Ave
Gary, IN 46406

Office #: (855) 817-5872
Fax #: (219) 228-7445

Injury #: (866) 622-7348

Terms

- I understand that I am responsible for notifying my employer immediately.
  - In the event of a work-related incident; injury or illness; and/or
  - If I need medical attention for any injury or illness that occurs at work.
- I understand the information I documented above regarding an incident/accident that occurred on the job entitles me to receive medical attention.
- Understanding this right, I am declining medical evaluation and treatment at this time.
- By reporting the incident/accident per our company's policy, even though I am declining medical treatment, I do hold the right to seek medical treatment at a later time (if directed through my employer and/or 1Source).
- By declining medical attention today, I will be responsible for notifying my employer of any changes in my condition. I also understand that I may be required to undergo a Fitness for Duty evaluation if my employer feels that I am at significant risk of harm to myself or others in the workplace, regardless of my decision to waive medical attention.
- I further understand that waiving medical attention does not exempt me from drug and/or breath alcohol testing per my company's policy.
- I understand that any medical attention I receive related to this incident/accident that is not coordinated through my employer or 1Source will be my own responsibility. This will include both financial and work status.
- I understand if I need to reach 1Source for injury assistance, they are available 24/7/365 at **(866) 622-7348**.

Employee Signature: _____ **Date:** _____

Witness: _____ **Date:** _____