

### Refusal of Medical Treatment for Injury

Date: \_\_\_\_\_ Employee Number: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

I have reported an injury to \_\_\_\_\_ on \_\_\_\_\_, and I am

refusing medical treatment at this time. I understand it is mandatory that I complete an Employee's Report of Injury and return the completed form to my immediate supervisor, or the Business Office. I have received an Authority for Treatment form and understand that I may go to any emergency room, or the following facility listed below for the first ten consecutive days after injury.

Henry Ford Macomb Health Center-Urgent Care  
80650 Van Dyke Rd  
Bruce Twp, MI 48065  
(810) 798-6410  
Hours: Mon-Fri 8:00 a.m. – 10:00 p.m.  
Sat & Sun 10:00 a.m. – 6:00 p.m.

Hurley Lapeer Urgent Care  
1794 N. Lapeer Rd.  
Lapeer, MI 48446  
(810) 969-4406  
Hours: Mon-Fri 10:00 a.m. – 10:00 p.m.  
Sat & Sun 10:00 a.m. – 6:00 p.m.

McLaren Convenient Care  
1181 S. Lapeer Rd.  
Lapeer, MI 48446  
(810) 667-7040  
Hours: Mon-Fri 9:30 a.m. – 5:30 p.m.  
Sat & Sun 10:00 a.m. – 2:00 p.m.

By signing this form, I am refusing medical treatment for my injury. If I choose to seek medical treatment, I understand I must abide by the policy stated above. I further understand that my injury is not considered work-related until approved by the worker's compensation carrier.

\_\_\_\_\_  
Employee's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor's Name

\_\_\_\_\_  
Date