



REFUSAL OF MEDICAL TREATMENT

AGREEMENT

I, _____ (name) have reported a job-related injury on _____ (date). I am refusing medical treatment for at this time for any job-related injury. I understand that if I do not follow the accident procedures, as reflected in my employment agreement or employment application, my injury will not be covered by Workers' Compensation and I am waiving my rights to any and all Workers' Compensation Benefits. I understand that in addition to the alcohol and drug screening agreed to in my employment application, state law allows an employer to require a drug and alcohol screen immediately upon medical treatment, or within the first twenty-four hours of an injury report, whichever comes first. And, by not complying with that law and Cornerstone PEO's Alcohol and Drug Screening Policy, I am intentionally waiving my rights to any and all Workers' Compensation benefits for this accident or injury.

Understood and agreed on _____, by _____
Date Signature

Date of Injury: _____

Social Security Number: _____

Witness Signature: _____ Date: _____

Witness Name (Print): _____