



REFUSAL OF MEDICAL TREATMENT OR OBSERVATION
FORM

Employee's Name (Print): Manuel Gonzalez

Work Location: Supervisor: dish pit

Witness(es): Connie

Nature of Injury/Condition: cut my Right hand

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

Brief Narrative Description of the Incident:

picking up a metal handle was Broken. cut
my Right hand

I, Manuel Gonzalez hereby acknowledge my refusal of medical treatment and/or observation offered to me at the expense of Acrobat Outsourcing for the work related injury I incurred on (date) 6-5-19. By signing this form, I realize that it does 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.

Manuel Gonzalez 6-6-19
Employee's Signature Date