



**REFUSAL OF MEDICAL TREATMENT OR OBSERVATION
FORM**

Employee's Name (Print): Reina Desir

Work Location: Supervisor: Stripe SF Zachary Ferreira

Witness(es): Lissa

Nature of Injury/Condition: Bun n

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

Brief Narrative Description of the Incident:

I was making a border and I BUNN
my self by accident,

I, Reina Desir, 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) 2/28/19. 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.

Reina Desir 2-30-19

Employee's Signature Date