



REFUSAL OF MEDICAL TREATMENT OR OBSERVATION  
FORM

Employee's Name (Print): Reina Desir

Work Location: Supervisor: Angelina Zekvar

Witness(es): lessa Lewis

Nature of Injury/Condition: Allergic Reaction

Description of Injury [Body Part(s) Injured]: Scratchy throat and arm/back

Brief Narrative Description of the Incident:  
Employee ate fish and had allergic reaction

I, Reina 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) 10/10/19. 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.

[Signature] 10/18/19  
Employee's Signature Date