EMPLOYEE INJURY NOTIFICATION FORM

I, _____, have reported a work-related injury to my supervisor and have been offered medical treatment and I have refused treatment. I do understand that if I do require medical treatment because of this injury, I will notify my supervisor. They will direct me to an authorized physician/clinic. Any unauthorized treatment will not be considered for payment. I will also submit to any required drug testing as the result of this injury.

_____ _____

Employee's Signature Date

_____ _____

Supervisor's Signature Date