VECTOR CONTROL JOINT POWERS AGENCY

DECLINATION OF MEDICAL ATTENTION

Employee's Name (please print)	Employer's Name
Date of Injury or Illness	Date of Treatment Offer
Description of Injury or Illness	
Body Part(s) Injured or Ill	

I have been advised by my employer that I may seek medical treatment related to the incident or illness described above. I do not wish to seek medical attention at this time, but will advise my supervisor or employer immediately should I wish to see a medical provider.

Absent a pre-designated physician, I understand that my employer has the right to select a medical provider for examination or treatment for the first thirty days following reporting of this injury or illness.

If I elect to seek medical treatment without advising my employer, I understand I may be responsible for the total cost of said treatment.

Employee's Signature	Date
Name of Employer Representative (please print)	Date
Signature of Employer's Representative	