



Medical Waiver Statement Form

To: Navajo Nation Workers' Compensation Program
 Post Office Box 2489
 Window Rock, Arizona 86515

Attention: Claims Section

Regarding:

Injured Workers' Name: _____

Date of Injury: _____

Last 4 Digits of Social Security Number; XXX-XX-_____

Type of Injury of Injuries: _____

This is to report that I did not seek medical treatment for the above injury or injuries because of the following reason(s):

- The injury was treated by First Aid at my place of employment or worksite
- The injury was minor and did not have any visible signs of evidence of trauma
- I did not think that medical treatment was necessary
- Other reason(s)

I understand that I should seek medical treatment for all injuries immediately, regardless of how minor they may appear. I will get medical attention in the event that my injury or injuries should become inflamed or get worse.

I agree to report any and all changes to my injury and injuries to your office immediately or to my supervisor.

Injured Workers' Signature: _____

Date signed: _____