MEDICAL WAIVER STATEMENT FORM

TO: 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 or 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 it may appear. I will get medical attention in the event that my injuries or injuries should become inflamed or get worse.

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

Injured workers' Signature: _____

Date Signed: _____