County of Spartanburg

Workers' Compensation

REFUSAL of TREATMENT

Date:___________________________ Employee Name:_____________________________

As of the above noted date, I am hereby notifying Spartanburg County of an injury that occurred on (date)_________________________________. I injured (body parts) _____________________ ________________ during this accident. I initially reported this injury to my supervisor on (date) ___________________________________.

The aforementioned accident did occur while I was employed with Spartanburg County and while performing my assigned duties.

At this time, a representative of Spartanburg County has requested that I be medically evaluated by Spartanburg County's preferred health care provider. However, I **DECLINE** to be medically evaluated for the above injury. I understand that by signing this document any future claims regarding this injury will require a medical evaluation by the Spartanburg County health care provider as noted below. I also understand that should I decide to seek medical treatment for this injury, I must immediately notify my supervisor and go to the below listed provider.

Spartanburg Regional Occupational Health
8311 Warren H. Abernathy Highway (Highway 29 just past Target)
Spartanburg, SC 29301
864/562-5100
Note: Should the condition become life threatening;
you should seek appropriate emergency medical care.

STATEMENT: I have read the above information and it is a factual and true statement. I authorize any physician, hospital, or health care provider to release and furnish any, and all, medical records or other information pertaining to the above listed condition.

_____________________________________ Employee Signature

_____________________________________ Supervisor/Witness Signature

_____________________________________ Date

_____________________________________ Date