



Treatment Refusal Form
(To be completed by employee)

Employee Name: _____

Date of Injury: _____

Part of Body: _____

Description of Accident: _____

I understand that I am entitled to medical treatment paid for by DSK Group and affiliates for my work related accident. This is to confirm that _____ offered me medical care as a result of the accident that occurred on _____. I understand that in order to receive medical attention I am required to go to an approved medical provider and obtain authorization from DSK Group and affiliates or their servicing agent prior to receiving medical treatment and get a drug test. By failing to obtain prior authorization before receiving treatment and required drug testing, the medical treatment will not be paid for by DSK Group and affiliates. **HAVING BEEN SO ADVISED I HAVE ELECTED TO DECLINE MEDICAL TREATMENT AND DRUG TESTING FOR THIS INJURY.**

Reason for declining medical treatment: _____

Employee Printed Name

Date

Employee Signature

Date