North Carolina Judicial Branch
Waiver of medical treatment

This form is to be completed in full by the employee involved. All questions must be answered, and detail questions should be thoroughly answered. Once complete, forward to NCAOC Safety & COOP team via email at Judicial.SafetyCOOP@nccourts.org or fax at 919-890-1905 or 1906

Date: _____ Employee Name: _____

Home Address: _____

Personal Telephone: _____ Work Telephone: _____

Social Security Number: _____ Sex: ☐ M ☐ F

Date of Birth: _____

Employer's Name: _____

Employer's Address: _____

Date of Incident: _____ Location of Incident: _____

Specific Body Part(s) Involved/Affected: _____

_____

Describe in Full Detail How Incident Occurred: _____

_____

_____

_____

Date Supervisor Notified: _____ Supervisor Name: _____

I am notifying the North Carolina Judicial Branch of a workplace place incident that resulted in bodily injury. Although it has been requested that I seek medical treatment, I decline to be medically evaluated for the above noted condition. I understand that by signing this document any future claims regarding this injury will require a medical evaluation. I also understand that should I decide to seek medical treatment for this injury that I must immediately notify my supervisor and go to an in-network authorized treating provider.

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

Employee Signature: _____

Supervisor Signature: _____