



Workers Denial of Need for Medical Care

Date: _____

Employee: _____

Employee ID#: _____

Social Security #: _____

Date of Injury: _____

Type of Injury: _____

Program: _____

I have reported a work-related injury to my employer, Fresno County Economic Opportunities Commission. I hereby confirm that I do not request to be seen by a physician at this time for the above-captioned industrial episode. I am capable of all of my normal activities of daily living, without restriction, and have no residuals resulting from this injury. If my injury does not improve, I will immediately inform my employer.

Employee Signature

Date

Supervisor Signature

Date