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Atlanta Corporate Office: 2 Ravinia Dr. Suite 270 Atlanta GA 30346
Toll Free: (877) 213-1999 Local: 678-262-3200
Fax: 678-262-3201 General Email: info@insuredsolutions.net

REFUSAL OF DOCTOR'S CARE

I,____, HEREBY STATE ON____________________________

(YOUR NAME) (DATE)

I, ____

(DESCRIPTION OF INJURY)

____

____

____

I UNDERSTAND THAT I AM REQUIRED TO UNDERGO A POST ACCIDENT DRUG/ALCOHOL TEST AT THE TIME OF THE ABOVE INCIDENT/INJURY.

I MISSED LESS THAN 4 HOURS FROM WORK. YES NO

I RETURNED TO REGULAR WORK ON ________________/________________/________________

(DAY) (MONTH) (YEAR)

____________________	____________________	__________
EMPLOYEE SIGNATURE	**PRINT NAME**	**DATE**
____________________	____________________	__________
SUPERVISOR SIGNATURE	**PRINT NAME**	**DATE**

Comments: (Employee or Employer)____

____

____

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