



CALIFORNIA HORSEMEN'S SAFETY ALLIANCE

**REFUSAL OF MEDICAL TREATMENT FOR
WORK RELATED INJURY UNDER
WORKERS' COMPENSATION BENEFIT**

I, _____ incurred an injury on _____

While working for Trainer _____

At, _____

Medical treatment was offered to me at the time of the injury and I refused to accept the medical treatment at that time.

Signed: _____
Employee

Date: _____

Signed: _____
Supervisor

Witness