Hamburg Area School District
Office of Human Resources
701 Windsor Street
Hamburg, PA 19526
Telephone: 610-562-2241 x 1741
Email: carcol@hasdhawks.org
Fax: 610-562-2634

Workers' Compensation Medical Treatment Waiver Form

I decline to seek medical treatment for an incident that I reported as having occurred during the course and scope of my employment on (date) ___________________________.

Although I am waiving medical treatment at this time, I have submitted the **"Employee Acknowledgement"** and "**Employee Statement of Injury or Illness**" documents with this form, as is required by my employer's Workers' Compensation carrier.

My employer has provided me with their Workers' Compensation panel provider list, and I understand that I have 120 days from the date of the incident to seek medical treatment for work related injuries requiring medical attention. I agree to notify my employer immediately should I choose to seek medical attention on a later date.

I indicate by signing below that I have been informed of my rights and responsibilities relating to workplace injuries and <u>I do not wish to seek medical treatment at this time</u>.

Employee Name: (Full Name) ______________________________

Employee Signature: ______________________________

Signature Date: ______________________________

Witness Name (Full Name): ______________________________

Witness Signature: ______________________________

Signature Date: ______________________________

Workers' Compensation Insurance Company:

Amtrust North America / P.O. Box 94405 Cleveland, OH 44101 / Phone: (888) 239-3909
Policy Effective Date: July 1, 2020 through June 30, 2021

Please report immediately any injury or work-related illness to your direct supervisor and to HR.