International Association of
Plumbing and Mechanical Officials
World Headquarters | humanresources@iapmo.org | www.iapmo.org
4755 East Philadelphia Street, Ontario, CA 91761

TREATMENT WAIVER FORM

Please complete appropriate sections, read each statement below, and initial where indicated next to each statement. After reading the form, sign and date at the bottom where indicated.

Name of Employee (print): _____ Date: ___ / ___ / ___

Company: _____ Department: _____

Time of Injury: _____ : _____ Location where injury occurred: _____

Body Part(s) affected: _____

Describe injury: _____

Type of activity being performed at time of injury: _____

Employee's Initials	***Statement***
	1. I believe I have sustained a work related injury or illness, or have been involved in a work related accident as has been reported to Human Resources on ___ / ___ / ___ (date).
	2. I hereby acknowledge that the Company has responded timely to offering me treatment and a DWC-1 form to complete, but that I have elected to complete this form instead.
	3. I understand that the decision to not seek treatment at this time is strictly voluntary and is solely my own decision, made of my own free will. I acknowledge that I have not been influenced or coerced to decline medical treatment at this time by any of my co-workers, supervisors, management, or any other person representing the Company.
	4. I hereby agree to decline treatment at this time because _____ _____..
	5. I understand that this treatment waiver does not exclude me from seeking treatment from the Company's industrial clinic or its assigned medical practitioner for this same injury within one (1) year from the date of injury or accident. As such, I agree to notify my supervisor immediately should I determine that treatment for this illness/injury is necessary.
	6. I understand that because I sustained a possible work related injury or illness, or was involved in a work related accident, that I may still be subject to taking a drug/alcohol test in order to comply with the Company's post accident/injury policies and that if I refuse, I may be in violation of such policies and be subject to disciplinary action, up to and including termination of my employment.
	7. I understand that at any future date should I seek medical treatment from my own private medial practitioner for this possible work related injury/illness, such services would be at my own expense and may not be covered by workers' compensation laws.
	8. I understand that the Company may exercise its rights and require me to be assessed under a "fit for duty" exam to ensure I am able to perform my job duties without sustaining further injury to myself and/or to others.
	9. I understand that should I NOT seek treatment for this possible work related injury/illness within the one (1) year statute of limitations, my rights for treatment from this claim may be revoked, requiring a new claim to be submitted, provided treatment is still necessary.

SIGNATURES:

I hereby agree that I have read, understood, and initialed each of the statements listed above.

Injured Employee's Signature:_____ Date: ___ / ___ / ___

Signature of Employee's Manager:_____

Human Resources: _____ Date Received: ___ /___ / ___