

## **Baldwin County Personnel Department Medical Treatment Waiver**

Baldwin County Commission is concerned with every employee's well-being. In the event you elect not to seek medical attention for this alleged Worker's Compensation Injury, we need to document that the Baldwin County Commission has not influenced, in any way, your decision to not seek treatment.

Employee Name: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Description of Accident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Description of Injury: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

My signature confirms that I have voluntarily waived medical care due to the injury indicated above. Should it later be determined that I require medical care, I will consult with my Supervisor prior to seeking treatment for this injury, unless emergency treatment is required.

\_\_\_\_\_  
Direct Supervisor Signature / Date

\_\_\_\_\_  
Safety Coordinator Signature/ Date

\_\_\_\_\_  
Appointed Dept. Director Signature / Date

\_\_\_\_\_  
Employee Signature / Date

\_\_\_\_\_  
Risk Manager Signature / Date

\_\_\_\_\_  
Personnel Director Signature / Date