American Payroll and Benefits I, LLC
PO Box 189 Ocala, FL 34478
Phone: 352-624-1999 Fax: 352-342-9356

EMPLOYEE REFUSAL

Employee Name:_____

S.S. Number:_____ **Date:**_____

Employer Name:_____

Please Check The Box That You Feel Is Appropriate

☐ I am refusing medical treatment (see description of accident below), but will undergo a post accident drug test and release the results to American Payroll and Benefits I, LLC.

☐ I require medical treatment (see description of accident below), but I am refusing post accident drug testing. I understand I may be required to pay all costs of my medical treatment.

☐ I am refusing both medical treatment (see description of accident below) and a post accident drug test and understand that I may be required to pay all costs of my medical treatment if sought in the future.

Injury occurred on _____/_____/_____

Please Describe Accident Below:

_____

_____

_____

_____

My signature indicates this refusal. I also understand that if injured, my refusal may mean that I forfeit eligibility to receive workers' compensation benefits.

_____ _____
Signature **Date**

_____
Printed Name

_____ _____
Witness Signature **Date**

_____
Witness Printed Name