# Refusal of Medical Care Against Medical Advice

**Employee Name:** ______________________________ **Date:** _____________

## Acknowledgement of Information (Initials on line)

________ I have been advised that medical care on my behalf is recommended, and that refusal of care and assistance could be hazardous to my health, and under certain circumstances, could include disability or death.

________ I acknowledge that I may have a medical problem which may require additional medical attention and an ambulance is available to transport me to a hospital which I am refusing transportation for further medical evaluation and/or treatment.

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## Release of Liability (Initials on line)

________ By signing this form, I am releasing (Insert Name of Company) of any liability or medical claims resulting from my informed decision to refuse care against medical advice.

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I have read and understand the Acknowledgement of Information and Release of Liability.

X ______________________________ ______________________________

Employee Signature Date

***If you change your mind, or your condition(s) changes, call 911 in an emergency, go to your local emergency room, or call your private doctor, if appropriate.***

**Witness #1**

______________________________ ______________________________

Witness Signature Date

**Witness #2**

______________________________ ______________________________

Witness Signature Date

**Witness #3**

______________________________ ______________________________

Witness Signature Date