ONESOURCE BUSINESS SOLUTIONS, LLC
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REFUSAL OF DOCTOR'S CARE

I, _________________________________ , hereby state that on ____________________________
(Your Name) (Date)

I, ____
(Full Description of Injury)

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I have reported the above injury to my worksite manager and OneSource Business Solutions. I have been offered medical treatment, but am refusing medical treatment at this time. I understand that I am required to undergo a post accident drug/alcohol test within 8 hours of reporting this injury. I understand that state law allows an employer to require a drug screen within 8 hours of reporting an injury, and by not complying with that law; I may not be covered by Workers' Compensation for this injury.

I further understand that should I need to seek medical treatment relating to this injury in the future, it will be necessary for me to contact OneSource Business Solutions. OneSource will make arrangements for treatment by a doctor listed on the pink physicians' panel (WC-P3) posted at my worksite.

I missed less than 4 hours from work. ____YES ___NO

I returned to regular work on _______________ / _________________ / __________________
Month Day Year

_______________________________ /______________________________ /_______________________
Employee Signature Print Name Date

_______________________________ /______________________________ /_______________________
Supervisor Signature Print Name Date