



THE NAVAJO NATION
WORKERS' COMPENSATION PROGRAM

RUSSELL BEGAYE PRESIDENT
JONATHAN NEZ VICE-PRESIDENT

MEDICAL WAIVER STATEMENT FORM

TO Workers' Compensation Program
Post Office Box 2489
Window Rock, Arizona 86515

ATTENTION CLAIMS SECTION

REGARDING:

Injured worker's name: _____

Date of Injury: _____

Last 4 digits of social security number: xxx-xx-_____

For identification purposes

Type of injury or injuries: _____

This is to report that I did not seek medical treatment for the above injury or injuries because of the following reason(s):

The injury was treated by First-Aid at my place of employment or worksite.

The injury was minor and I did not have any visible signs or evidence of trauma.

I did not think that medical treatment was necessary.

Other reason(s): _____

I understand that I should seek medical treatment for all injuries immediately, regardless of how minor it may appear. I will get medical attention in the event that my injury or injuries should become inflame or get worse.

I agree to report any and all changes to my injury or injuries to your office immediately or to my supervisor.

Injured worker's Signature: _____

Date Signed: _____