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-_____

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 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 see 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 inflamed 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: _____