



**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

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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: \_\_\_\_\_