

HR OUTSOURCING, INC.
1588 Atkinson Road, Suite 201
Lawrenceville, GA 30043
770-349-8880

REFUSAL OF DOCTOR'S CARE

I, _____, hereby state that on _____
(Your Name) (Date)

I, _____
(Description of Injury)

I understand that I am required to undergo a post accident drug/alcohol test at the time of the reporting of the above incident.

I missed less than 4 hours from work. Yes No

I returned to regular work on _____ / _____ / _____
Day Month Year

Employee Signature / Print Name / Date

Supervisor Signature / Print Name / Date