

# Decline Medical Treatment Form

Fax or Email this completed form to FAS (972) 930-9479 or [CLAIMS@FASTPA.COM](mailto:CLAIMS@FASTPA.COM)

**EMPLOYER INFORMATION:** \_\_\_\_\_

ADDRESS: \_\_\_\_\_ City: \_\_\_\_\_ State TX Zip: \_\_\_\_\_

PHONE: (\_\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_\_) \_\_\_\_\_ Policy# \_\_\_\_\_

I \_\_\_\_\_ choose to decline medical treatment that has been offered to me for an injury that was sustained on \_\_\_\_\_. I am aware that by declining medical treatment at this time, that my employer, \_\_\_\_\_ will not be responsible for any medical expenses or lost wages unless specifically approved by \_\_\_\_\_.

Employer

\_\_\_\_\_

Employee

\_\_\_\_\_

Employer Representative

\_\_\_\_\_

Date