Beverly Hills Unified School District
Administrative Office
Phone (310) 551-5100 x2248 Fax (310) 551-5505

WAIVER OF MEDICAL ATTENTION

DATE: _____

EMPLOYEE NAME: _____

JOB TITLE: _____

WORK LOCATION: _____

TYPE OF INJURY: _____

I understand that as an employee of Beverly Hills Unified School District, I am entitled to receive medical attention when I sustain an injury/illness on the job.

At this time I do not wish to seek medical attention for the injury/illness I sustained on _____.
Date of injury

_____ _____
Employee's Signature Date

I understand that I have one year from the actual injury date to seek medical attention. If I decide to seek medical attention, I can be treated at one of the following medical facilities:

Midway Industrial Health Care Services

NOTE TO SUPERVISORS

This form must be submitted along with the "Supervisor's Accident Investigation Report" to the Administrative Office within 24 hours.

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