Beverly Hills Unified School District
Human Resources Office
Phone (310) 551-5100 x2237 Fax (310) 227-6137

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 the following medical facility:

Midway Industrial Healthcare Services

NOTE TO SUPERVISORS

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

Rev. 2/28/11