THE NAVAJO NATION

JONATHAN NEZ | PRESIDENT   MYRON LIZER | VICE PRESIDENT

MEDICAL WAIVER STATEMENT FORM

TO   Worker's Compensation Program
Post Office Box 2489
Window Rock, Arizona 86515

Attention   CLAIMS SECTION

REGARDING:

Injured Workers' 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 seek medical treatment for all injuries immediately, regardless of how minor it may appear. I will get medical attention in the event that my injuries 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: ______________________________