MEDICAL TREATMENT WAIVER
State Form 54953 (3-12)
INDIANA DEPARTMENT OF TRANSPORTATION

Reset Form

Name of Employee:	PeopleSoft Number:
District/Central Office:	Sub-district/Department:

By signing this waiver, I fully understand that I am refusing authorized medical treatment under the State's Worker's Compensation Program. This treatment was offered due to an alleged injury that occurred at my work site on the following date: _____ and I do not want to pursue a worker's compensation claim at this time.

I fully understand that all medical bills will need to be filed under my group health insurance and I will not be entitled to any lost time wages if I miss any work. I also understand that in the future if I wish to pursue this claim for consideration under worker's compensation, that no bills or lost time wages prior to the date of my consideration will be covered under worker's compensation.

_____ Signature of Employee	Date *(month, day, year)*:
_____ Signature of Supervisor or their designee or Employee	Date *(month, day, year)*:
_____ INDOT Human Resources Generalist or their designee	Date *(month, day, year)*: