CITY OF HIALEAH

TO BE COMPLETED ONLY IF EMPLOYEE DOES NOT SEEK MEDICAL TREATMENT AT THE TIME OF INJURY

ADDENDUM 1

Name of Injured: _____ Social Security Number: _____

Job Title: _____ Department/Division: _____

Date of Injury _____ Time: _____ Body Part: _____

Description of injury/illness, including the cause of injury: _____

_____

Location of the injury: _____

_____ _____ _____

Supervisor Name Date Supervisor Signature

I, _____, hereby acknowledge at this time no need of medical treatment offered to me for the work-related injury I incurred on (date) _____ at (location) _____. By signing this form acknowledging no need to receive medical treatment, **I understand that I am not waving my rights to receive workers' compensation benefits,** but I do acknowledge that if I want to receive workers' compensation benefits in the future I have a responsibility to notify my employer in writing that I want and/or need medical care for my injury. I acknowledge that my supervisor(s), in good faith, have offered and made available to me an opportunity to file a First Report of Injury and to seek necessary medical treatment. **I understand that there are time limitations for which I may bring a claim for workers' compensation benefits which are controlled by Chapter 440 of the Florida Statutes. I understand that pursuant to Section 440.19 of the Florida Statutes I have 2 years from the date of my injury or illness to file a claim for workers compensation benefits.** Additionally, my eligibility for benefits may also be eliminated one year from the date I last receive a wage replacement check from workers' compensation or I received authorized medical care through workers' compensation.

Employee signature: _____ **Date:** _____

_____ _____ _____

Case Re-open **Employee signature** **Supervisor Signature**