

## Right of Refusal of Medical Aid Questionnaire

Production/Event Company \_\_\_\_\_

Project/Event Title \_\_\_\_\_

You've received this form because you have refused or declined an initial offer of treatment from (or transportation to) a medical/health provider.

I, \_\_\_\_\_, hereby refuse the first aid treatment or transportation for medical treatment to a health provider for the illness or injury incurred by me on this date \_\_\_\_\_.

In signing this waiver, I relieve the production/event company and Cast & Crew/CAPS from any and all liability or damages resulting from this refusal to accept such first aid treatment.

\_\_\_\_\_  
Employee Name (Print or Type)

\_\_\_\_\_  
Job Title or Position

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Supervisor Name (printed)

\_\_\_\_\_  
Medic Signature

\_\_\_\_\_  
Medic Name (printed)

**Should your condition require further medical treatment, please contact Cast & Crew immediately at [workcomp@castandcrew.com](mailto:workcomp@castandcrew.com). Please submit via email or fax the completed copy of this form to Cast & Crew within 24 hours of knowledge of injury.**