

Post – Exposure Medical Treatment
Declination Form

I understand that due to my occupational exposure I may be at risk for acquiring _____ disease. I have been given the opportunity to be treated prophylactically for this exposure at no charge to myself. However, I decline follow-up medical treatment at this time. I understand that by declining this treatment, I continue to be at risk for acquiring the disease to which I have been exposed. I understand that if I acquire this disease I will be placed under the department's work restriction guidelines.

Name _____

Signature _____ Date: _____