

RIGHT OF REFUSAL OF MEDICAL AID

Department: _____

I hereby refuse the first aid treatment recommended to me by the WBSF First Aid employee for the illness or injury incurred by me on this date.

In signing this waiver, I release the First Aid Person, Warner Bros. Studio Facilities Inc. and its personnel from any liability resulting from this refusal to accept such first aid treatment.

Injured's or Guardian's Signature

Date

Injured's Name (print)

Job Title or Position

Guardian's Name in case of minor

Relationship to Injured

First Aid Person Signature

First Aid Person Name (print)

Witness Signature

Witness Name (print)

This form should be signed, dated and returned to the Department Head.