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) Injured's Cell # 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) Witness Cell #

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

NOTES: _____

_____

_____