Complete only if employee declined medical treatment

DECLINATION OF WORKERS' COMPENSATION BENEFITS (MEDICAL TREATMENT)

I, ________________________________ decline medical treatment for injury/illness I incurred
(Employee)
on ______________________. I understand that I may be entitled to workers' compensation benefits,
(Date)
examination and/or treatment as a result of my work injury/illness.

I understand this declination is a voluntary decision and does not waive my rights under Workers Compensation Benefits as set forth by the State.

I acknowledge that my supervisor(s) have offered and made available to me an opportunity to seek necessary medical treatment and/or observation.

I agree to notify my employer immediately if, in the future, I feel medical treatment for this injury becomes necessary and will I want to seek medical treatment.

I was also provided a DWC-1 form

Comments:

__________________________________ ____________________________
Employee Signature Date

__________________________________ ____________________________
Supervisor Signature Date