Insert District Name.....

WORKERS' COMPENSATION PROGRAM

Declination of Medical Examination/Treatment

Name of Employee: _____

Job Title: _____

Date & Time of Incident: _____

Location of Incident: _____

Description of Incident:

_____ My signature below confirms that I AM NOT experiencing any signs or symptoms resulting from the incident described above. Insert District Name..... has offered medical treatment to me; however, I decline any medical evaluation or treatment as a result of this job-related incident.

_____ My signature below confirms that I AM experiencing signs or symptoms resulting from the industrial incident described above. Insert District Name..... has offered medical treatment to me; however, as I feel my symptoms are improving, I decline any medical evaluation or treatment as a result of this job-related incident.

If the need for medical treatment arises as a result of this incident, I have been instructed to inform Human Resources immediately.

_____ _____

Signature of Employee Date

_____ _____

Signature of WC Representative Date

This document is not a waiver of workers' compensation benefits as stated by Labor Code 5405(a), where no benefits have been provided, the injured worker has a maximum period of one year from the date of injury to obtain medical treatment and benefits.