Declination of Worker's Compensation / Medical Treatment

Employee's Name: _____

Job Title: _____ Work Site: _____

Date of Incident: _____ Time of Incident: _____ AM/PM

Date Reported: _____ Time Reported: _____ AM/PM

Description of Injury/Illness to body: _____
(Please be specific: i.e. bruised left knee, cut on right index finger)

- **If employee declines to accept the DWC1 form; they must read, understand, and sign below**.

DECLINATION TO COMPLETE DWC-1 CLAIM FORM

I have been offered the Workers' Compensation Claim Form (DWC-1) and have chosen not to accept and/or complete it. I do not want to file a claim for Workers' Compensation and do not wish to exercise my right at this time. I do not need medical attention for this injury/illness.

_____ _____/_____/_____
Employee's Signature ***Date***

- **If the employee declines medical treatment**, yet wishes to report the incident, provide the employee with the Workers' Compensation Claim form (DWC-1). The employee must sign below, indicating he/she has received the DWC1, and has been offered medical treatment but has chosen to decline.

DECLINATION OF MEDICAL TREATMENT

I have received the DWC-1 form and at this time I decline medical treatment for the injury/illness indicated on this form. I understand if I choose to consult a physician at a later date for this incident, I must first notify my supervisor and Human Resources.

_____ _____/_____/_____
Employee's Signature ***Date***

_____ _____
Supervisor's Name (Print) Supervisor's Phone Number

_____ _____ AM PM
Supervisor's Signature Date and Time

Upon completion of this form, immediately forward this form with the completed Supervisor's report and the Employer section of the DWC-1 form to Charlene Nakama, Human Resources (ext. 5152).

05/27/14