DECLINATION OF MEDICAL TREATMENT

EMPLOYEE INFORMATION

Employee Name: _____Job Title: _____

INJURY/ILLNESS INFORMATION

Date of Injury/Incident: _____ Time: _____ Date Reported: _____

Body part(s):_____

MEDICAL TREAMENT

I sustained a work related injury; at this time I do not feel the need to seek medical treatment. I acknowledge that my employer has offered me the opportunity to go to the frontline medical provider. If the need for future medical treatment arises as a result of this injury I understand that I am to notify my supervisor immediately.

DWC 1 & MPN

I acknowledge that my employer has provided me with a DWC-1. If in the future I wish to file a workers' compensation claim for this incident, I will need to complete the form and return it to my supervisor. I also acknowledge that I have received the complete employee rights notification for the Medical Provider Network.

EMPLOYEE SIGNATURE

_____ _____

(Signature) **(Please Print Name)**

Date:_____

SUPERVISOR SIGNATURE

_____ _____

(Signature) **(Please Print Name)**

Date:_____