DECLINATION OF WORKERS' COMPENSATION BENEFITS

(MEDICAL TREATMENT)

I, _____, understand that I am entitled to workers' compensation benefits, examination and/or treatment under my employer's workers' compensation insurance policy. I reported a potential work-related incident/injury/illness on _____.

As a result of the incident, I experienced an:

☐ Injury

Body part affected: _____

Job duty performed when injury occurred: _____

Date of injury: _____

☐ Illness

Illness: _____

Location of exposure: _____

Date of exposure: _____

I understand this declination is a voluntary decision and does not waive my rights under workers' compensation benefits as set forth by the state of California. I agree to notify my employer immediately, if, in the future, I feel medical treatment for this incident/injury/illness becomes necessary and I want to seek medical treatment.

_____

Employee Name (Printed)

_____ _____

Employee Signature Date

_____

Authorized Employer Name (Printed)

_____ _____

Authorized Employer Signature Date