DECLINATION OF WORKERS' COMPENSATION BENEFITS (MEDICAL TREATMENT)

I,___________________________________understand that I am entitled to Workers'
(employee)
Compensation benefits, examination and/or treatment under my Employer's Workers' Compensation Policy.

I reported a work-related incident/injury on________________________. As a result
(date)
of the incident, I injured my ____
(body part)
while performing____job task.

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 injury becomes necessary and will I want to seek medical treatment.

I was also provided a DWC-1 form.

____
Employee Signature

____
Authorized Employer Signature

____
Date