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 **Date**

Employer **Date**