

DECLINATION OF MEDCIAL 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) Date:		(Please Print Name)
SUPERVISOR SIGNATURE		
(Signature) Date:		(Please Print Name)