Employee's Declination of Workers' Compensation/Treatment

Name of Injured/Ill Employee: _____

Job Title: _____ Work Site: _____

Date of injury/illness: _____ Time of injury/illness: _____ AM/PM

Date reported: _____ Time reported: _____ AM/PM To whom? _____

☐ DECLINATION TO COMPLETE DWC 1 CLAIM FORM

If the employee declines to accept forms, he/she must read, understand, and sign below.

I have been offered the Workers' Compensation Claim Form (DWC-1) and have chosen not to accept and/or complete it. I do not have a desire to file a claim for Workers' Compensation pertinent to the injury/illness described in this report. I understand my rights regarding Workers' Compensation and do not wish to exercise them at this time. I do not need medical attention for this injury/illness.

_____ _____ _____

Employee's Full Name (print) Date Employee's Signature

☐ DECLINATION TO RECEIVE MEDICAL TREATMENT

If the employee declines medical treatment, yet wishes to report the injury, provide Workers' Compensation Claim Form (DWC-1) to the injured/ill employee. The employee must sign below, indicating he/she has received the above-mentioned forms, been offered medical attention and has chosen to decline medical treatment.

I have declined to accept medical treatment offered to me for the injury/illness discussed in this form.

_____ _____ _____

Employee's Full Name (print) Date Employee's Signature

Upon completion of this form, immediately forward to the person in charge. The person in charge will place in employee's medical file.