EMERGENCY PET INTENSIVE CARE

Employee Declination of Worker's Compensation/Treatment

Name of Injured/Ill Employee: _____

Job Title: _____

Date of Injury/Illness: _____ **Time of Injury/Illness**: _____ AM/PM

Date Reported: _____ **Time Reported**: _____ AM/PM

Injury/Illness Reported To (Name): _____

Describe injury and part of body affected:

_____

_____

_____

☐ Declination to Complete DWC 1 Claim Form

If employee declines to accept forms, they must read, understand, and sign below.

I have been offered the Workers' Compensation 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 Name (Print) Date Employee Signature

☐ Declination to Receive Medical Attention

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 Name (Print) Date Employee Signature

Upon completion of this form, immediately forward to human resources.