Workers' Compensation – Treatment Waiver Form

Please complete this form if you are choosing to decline medical treatment at this time.

Employee Information

Employee Name: _____ Date of Injury: _____

Department: _____ Location of Injury: _____

Supervisor: _____ Body Part(s) Affected: _____

Describe the injury:

_____

_____

_____

_____

Employee Acknowledgement

1. I reported my work-related injury/illness to my employer on the date listed above.
2. The company has offered me medical treatment and provided me with a DWC-1 form.
3. I am voluntarily declining medical treatment at this time.
4. I understand that I may request medical treatment later, within one (1) year from the date of injury, under workers' compensation law.
5. I understand that declining treatment at this time does not affect my right to file a workers' compensation claim.

Signatures

Employee Signature: _____ Date: _____

Manager/HR Signature: _____ Date: _____