Pasadena City College
Risk Management Services

DECLINATION OF MEDICAL TREATMENT

EMPLOYEE INFORMATION

Employee Name: ____________________ Title: ____________ Department: ___________

INJURY/ILLNESS INFORMATION

Date of Injury/Incident: _________________ Time: _______ Date Reported: ____________

Body part(s): ____

MEDICAL TREATMENT

I sustained a work-related injury. However, I do not feel the need to seek medical treatment at this time. I acknowledge that my employer has offered me the opportunity to be treated at a medical facility. If the need for future medical treatment arises due to this injury, I understand that I must notify my supervisor and Risk Management Services immediately.

WORKERS' COMPENSATION CLAIM FORM

I acknowledge that my employer has provided me with a Workers' Compensation Claim form and Notice of Potential Eligibility. 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 Risk Management Services.

EMPLOYEE SIGNATURE

________________________________ ________________________________

(Signature) **Print Employee Name)**

Date: ___________________________

RISK MANAGEMENT SERVICES SIGNATURE

________________________________ ________________________________

(RMS Signature) **(Print RMS Name)**

Date: ___________________________