

DECLINATION OF MEDICAL TREATMENT

I, _____, have been informed that I am entitled to
(PRINT NAME)
medical treatment of any job related injury that may have been suffered while in the
performance of my duties. I have elected to decline medical treatment at this time for my
injury incurred as a result of a job-related accident on _____.
(DATE)

(EMPLOYEE SIGNATURE)

(DATE)

(SUPERVISOR SIGNATURE)

(DATE)

NOTE: Attach to the completed LS-201, Notice of Employee’s Injury or Death, and LS-202, Employer’s First Report of Injury or Occupation Illness, and forward to HRO.