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.