



Employee's Declination of Workers' Compensation/Treatment

Name of Injured Employee: _____ Site: _____

Job Title: _____

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

Date Reported: _____ Time Reported: _____ AM/PM To Whom? _____

I have been offered the Workers' Compensation Claim Form (DWC-1) and have chosen not to accept and/or complete it. I do not desire to file a claim for Workers' Compensation pertinent to the injury/illness described above. 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's Full Name (print)

Date

Employee's Signature

Upon completion of this form, immediately forward with the Supervisor's Report of Injury/Illness to Ruby Ayala, Workers' Compensation Analyst, Room 1650, ext. 6630