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 to swcworkcomp@swccd.edu