Declination of Medical Treatment

SCHOOL SITE OR LOCATION WHERE INJURY OCCURRED	DATE OF INJURY	DATE OF REPORT
NAME OF INJURED EMPLOYEE	INJURED EMPLOYEE'S SCHOOL/DEPARTMENT	

DETAILS OF ACCIDENT:	
	My signature below confirms that **I am not** experiencing any signs/symptoms resulting from the industrial accident indicated above. Medical Treatment has been offered but I further decline any medical treatment as a result of this job-related accident.
	My signature below confirms that **I am** experiencing signs/symptoms resulting from the industrial accident indicated above. Medical Treatment has been offered but I further decline any medical treatment as a result of this job-related accident.

If the need for medical treatment arises as a result of this injury, I have been instructed to inform my supervisor and immediately contact Risk Management, Amelia Niño (760) 848-1106.

EMPLOYEE SIGNATURE	DATE

This document is not a waiver of workers' compensation benefits as stated by Labor Code 5405(a), where no benefits have been provided, the injured employee has a maximum period of one (1) year from the date of injury to obtain medical treatment and benefits.