Form C

WORKERS COMPENSATION
YMCA OF METROPOLITAN LOS ANGELES

DECLINATION OF MEDICAL CARE

Instructions for Injured Employee

Please read the Instructions for Injured Employees packet prior to completing this form. Please complete this form if you elect to decline medical treatment for your work-related injury or illness. Complete the information below and submit to your supervisor.

Employee Name: _____
First MI Last

Date of Injury: _____

Today's Date: _____

Date Supervisor Notified: _____

Body Part(s) Affected: _____

Incident Leading to Injury: _____

_____

_____

_____

Acknowledgment:
My employer has offered the opportunity to receive medical care for the above stated injury or illness in compliance with Labor Code 4600. I voluntarily choose to decline medical coverage as I do not require medical attention at this time. However, I understand that if I should feel the need to have care, I will immediately contact my supervisor or the Workers Compensation Administrator.

This statement only acknowledges that I have been given the opportunity to be examined and treated and in no way waive my rights under Workers Compensation laws.

Employee Signature: _____

For Office Use Only

Supervisor Name: _____
(please print)

Position Title & Contact Information: _____

Date Received: _____

Employer Representative Signature: _____