



## REFUSAL OF MEDICAL TREATMENT FOR WORK-RELATED INJURY

Employee Name

Date Reported

Date of Injury

Time of Injury

Location Where Injury Occurred

Supervisor Name

I hereby acknowledge refusal of medical treatment offered to me for the above-mentioned work-related injury. I understand that signing this form does not waive the right to future medical treatment for this injury.

I acknowledge that my employer, in good faith, has offered and made available to me an opportunity to seek necessary medical treatment and/or observation. I am aware that by declining medical treatment at this time, my employer will not be responsible for any future related medical expenses and/or lost wages\* unless I notify a supervisor/manager and participate in the workers' compensation process.

*\*Salary continuation is subject to claim approval status.*

I acknowledge that I have been provided with a printed copy of the "Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility" form.

Employee Signature

Employer Representative (Witness)

Name of Witness (if not the Supervisor listed above)

Date

Date

*Email completed form to: [workerscomp@fairfield.ca.gov](mailto:workerscomp@fairfield.ca.gov)*