DECLINATION OF WORKERS' COMPENSATION BENEFITS

(MEDICAL TREATMENT)

I, ________________________________ understand that I am entitled to workers'

(employee first, last name)

Compensation benefits, examination and /or treatment under the Saint Mary's College of California Workers' Compensation Policy.

I reported a work related incident/injury on ________________________________.

(date)

As a result of the incident, I injured my ____________________ while performing

(body part)

____job task.

I understand this declination is a voluntary decision and does not waive my rights under Workers Compensation Benefits as set forth by the State of California.

I agree to notify my employer immediately if, in the future, I feel medical treatment for this injury becomes necessary and will I want to seek medical treatment.

I was also provided a DWC-1 form.

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Employee Signature Date

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Employer Signature Date