EMPLOYER INFORMATION

Employer: _____

Treatment Authorized by: _____

Title: _____

Telephone Number: _____

INJURED EMPLOYEE INFORMATION

Employee: _____

Job Title: _____

Department: _____

Date of Injury: _____

Workers' Compensation Insurance Carrier: Waypoint Mutual (800) 374-7789

TREATMENT DECLINATION

I am ***declining*** my employer's offer of authorized medical treatment to cure and relieve the effects of the injury I am claiming to have sustained at work on _____ [insert date]. I understand that by declining my employer's offer of medical care, any treatment I obtain my own will be at my own expense.

I also understand that if I reconsider and am interested in receiving authorized medical care, I must advise my employer as soon as possible.

Employee Signature: _____ Date: _____ /_____ /_____

Remarks: