



DECLINATION OF MEDICAL TREATMENT FORM

If an injured employee declines medical treatment (other than first aid) they shall complete the form.

I, (Print Name) _____, have been offered medical treatment by my employer and have been advised of my right to file a Workers Compensation claim for my injury on (Date) _____ but I have elected to decline medical treatment. I understand that if I decide to seek medical treatment at a later date for the injury that occurred on (Date) _____, I shall IMMEDIATELY contact the Risk Management / Workers Compensation Department at (850) 689-5977 for further instructions BEFORE contacting a doctor or scheduling a medical appointment.

Employee Name (Print): _____

Signature: _____

Date: _____

Note: A [First Report of Injury](#) form is still required to be completed and signed by the employee.