CITY OF OXNARD CALIFORNIA

REPORTING ONLY
DECLINATION OF MEDICAL TREATMENT

Employee Name: _____ **Employee ID**: _____

Department: _____ **Job Title**: _____

Date of Injury: _____ **Time of Injury**: _____ **Date Reported**: _____

Witness: _____ **Location of Injury**: _____

Body Part(s) Injured: _____

Please describe how you were injured: _____

_____

_____

Were you wearing proper Personal Protective Equipment (PPE): _____Yes _____No

If *Yes*, describe the PPE you were wearing: _____

If *No*, explain why no PPE was worn: _____

I, _____ have been offered the opportunity to receive medical treatment for the above stated injury/illness by my supervisor/employer. I also acknowledge that I was provided with the *Workers' Compensation Claim Form (DWC-1*). At this time, I do not require medical treatment and do not wish to file a workers' compensation claim. I understand this declination is a voluntary decision and does not waive my rights under the Workers' Compensation Benefits as set forth by the State.

I understand that I must notify my supervisor immediately if I am in need of medical treatment related to this injury/illness in the future.

_____	_____	_____
Employee Signature	**Date**	**Phone #**
_____	_____	_____
Supervisor Signature	**Date**	**Phone #**

Upon completion, forward Declination form to CorVel and Risk Management via email to:
FNOL_FAX@corvel.com and wcinjuries@oxnard.org

For Police Dept injuries, please CC Eva Vazquez at eva.vazquez@oxnardpd.org.