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: _____

Description of injury/illness: _____

_____

_____

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 Laura Ledesma at laura.ledesma@oxnardpd.org.