SANTA PAULA UNIFIED SCHOOL DISTRICT

REFUSAL OF MEDICAL EXAMINATION AND/OR TREATMENT

Name of Employee _____

School/Site _____ Position _____

Date of Accident _____ Date Reported _____

PLEASE CHECK ONE

_____ My signature below confirms that **I am not** experiencing any signs or symptoms resulting from the industrial accident indicated above.

Medical treatment has been offered but I further decline any medical evaluation or treatment as a result of this job-related accident. I will complete the DWC form given to me by my employer to be kept on file.

_____ My signature below confirms that **I am** experiencing signs or symptoms resulting from the industrial accident indicated above. *However, I feel my symptoms are improving.*

Medical treatment has been offered but I further decline any medical evaluation and/or treatment as a result of this job-related accident. I will complete the DWC form given to me by my employer to be kept on file.

PLEASE INITIAL BELOW

_____ **If the need for medical treatment arises as a result of this injury, I have been instructed to inform my supervisor and to immediately contact Company Nurse (available 24 hours a day) at 1-855-602-5267.**

_____ _____

Signature of Employee Date

This document is not a waiver of Workers' Compensation benefits as stated by Labor Code 5405(a), where no benefits have been provided, the injured employee has a maximum period of one (1) year from the date of injury to obtain medical treatment and benefits.