



REDLANDS UNIFIED SCHOOL DISTRICT
20 W. LUGONIA AVENUE
REDLANDS, CA 92374

DECLINATION OF MEDICAL TREATMENT

Complete this document if you are DECLINING medical treatment at this time.

SCHOOL SITE OR LOCATION WHERE INJURY OCCURRED:	DATE OF INJURY:	DATE OF REPORT:
NAME OF INJURED EMPLOYEE:	INJURED EMPLOYEE'S SCHOOL/DEPARTMENT:	

DETAILS OF ACCIDENT:

	MY SIGNATURE BELOW CONFIRMS THAT I AM NOT EXPERIENCING ANY SIGNS/SYMPTOMS RESULTING FROM THE INDUSTRIAL ACCIDENT INDICATED ABOVE. MEDICAL TREATMENT HAS BEEN OFFERED BUT I FURTHER DECLINE ANY MEDICAL TREATMENT AS A RESULT OF THIS JOB-RELATED ACCIDENT.
	MY SIGNATURE BELOW CONFIRMS THAT I AM EXPERIENCING SIGNS/SYMPTOMS RESULTING FROM THE INDUSTRIAL ACCIDENT INDICATED ABOVE. MEDICAL TREATMENT HAS BEEN OFFERED BUT I FURTHER DECLINE ANY MEDICAL TREATMENT AS A RESULT OF THIS JOB-RELATED INJURY AT THIS TIME.

IF THE NEED FOR MEDICAL TREATMENT ARISES AS A RESULT OF THIS INJURY, I HAVE BEEN INSTRUCTED TO INFORM MY SUPERVISOR AND IMMEDIATELY CONTACT RISK MANAGEMENT (909) 307-5300.

EMPLOYEE SIGNATURE:	DATE:
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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.