



Risk Management Department
Voice: 858.627.7345
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Declination of Medical Treatment

Employee Name:	Employee ID:
Date Of Injury:	Affected Body Part:

- I _____ have advised my supervisor of an injury that occurred in the course of my employment on ____/____/____.
- I do not feel my injury warrants medical attention at this time.
- However, if I choose to consult a physician at a later date for my injury, I will first notify my supervisor.
- My supervisor will notify Risk Management Department as soon as possible.

Employee Signature

Date/Time

Signature of Contact/Supervisor

Date/Time

Print Name of Contact/Supervisor

Phone Number

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