CHAPMAN UNIVERSITY
Human Resources
One University Drive
Orange, California 92866
www.chapman.edu/hr
(714) 997-6686 • Fax: (714) 997-6901

WORKERS COMPENSATION MEDICAL TREATMENT DECLINATION FORM

I, _____, acknowledge that I have been offered medical treatment for a reported work related incident/injury sustained on _____. I have been offered workers compensation benefits for this work related incident/injury as per the rules and regulations concerning workers compensation in the state which I reside.

As indicated below by my signature below, at this time I am declining the offer for medical treatment and workers compensation benefits. Also, I understand that if at a later date I believe I will require medical treatment and/or other workers compensation benefits, I will inform Chapman University's Human Resources designated representative:

Tim Frenchcampbell
Wellness and Leave Administration Specialist
Department of Human Resources
Email: frenchca@chapman.edu
Phone: 714-997-6979

No further action will be taken by Chapman University at this time.

I also understand that, by signing this form, I take full responsibility for myself. I agree to absolve Chapman University, its subsidiaries and its employees, of any responsibility for harm that may result from my declination, and recognize their good faith effort to provide appropriate workers compensation benefits to include medical treatment. I understand this declination is a voluntary decision and does not waive my rights under Workers Compensation Benefits as set forth by the State of California. I was also provided a DWC-1 form.

_____ _____

Employee's Signature **Date**