Employee Medical Care Refusal and DWC1 Receipt

Place your logo here

On _____ I sustained an injury to the following body part/s_____. I was offered medical care but I have refused. My signature below documents my refusal of medical attention and acknowledges that I was provided a DWC1 Workers Compensation Claim Form and Notice of Potential Eligibility by my employer on the date noted. Should I need medical attention at a later date I will notify my employer immediately.

_____ _____

Date Signature

_____

Print Name

Spanish

El Dia _____ Yo me lesione en la/s siguiente parte/s del cuerpo_____ Me ofrecieron tratamiento medico pero no acepte. Mi firma abajo indica que no acepte atencion medica y que he recibido la forma DWC1 Workers Compensation Claim Form and Notice of Potential Eligibility de mi empleador en la fecha indicada. Si en el futuro necesito tratamiento medico le notificare a mi empleador inmediatamente.

_____ _____

Date/Fecha Signature/Firma

_____

Print Name/ Nombre en letra de molde