WORK COMP DECLINATION OF MEDICAL TREATMENT

DATE: _____

Employer Information

EMPLOYER: _____

TREATMENT AUTHORIZED BY: _____

TITLE: _____

PHONE NUMBER: _____

Injured Worker Information

EMPLOYEE: _____ SOCIAL SECURITY NUMBER: _____

TITLE: _____

DEPARTMENT: _____ LOCATION: _____

DATE OF INJURY: _____ BODY PART INJURED: _____

Treatment Declination

I am declining my employer's offer of authorized medical treatment to cure and relieve the effects of the injury I am claiming to have sustained at work on _____ (today's date). I understand that by declining my employer's offer of medical care, any treatment I obtain on my own will be at my own expense.*

I also understand that if I reconsider and am interested in receiving authorized medical care, I must advise my employer as soon as possible.

EMPLOYEE SIGNATURE: _____ DATE: _____

**If the employee desires, they shall have the right to select their own physician, surgeon, or other such requirement at their own expense. Section 287.140.1*

REMARKS: _____

_____

Submit completed form to: Missouri Employers Mutual Insurance
P.O. Box 1810, Columbia, MO 65205

Fax: 1.800.442.0597
Email: claims@mem-ins.com