DECLINATION OF WORKERS' COMPENSATION MEDICAL AND/OR PSYCHOLOGICAL TREATMENT

Employee Name: _____
(Please Print)

Date of Injury: _____ Claim Date: _____

I am NOT requesting medical treatment for my injury/illness that occurred on _____, at this time. I understand that by not requesting treatment, the State of New Jersey will have no information about my physical or mental condition as a result of the incident detailed in the attached Employer's First Report of Accidental Injury or Occupational Disease Form (RM-2).

If I seek unauthorized treatment on my own, I will be responsible for any medical bills incurred. I do understand that if my condition worsens or if I feel that it necessary to seek medical care as a result of the reported injury of _____, I am to contact my Human Resources Representative prior to seeing a State authorized physician. I further understand that my failure to following the instructions as outlined above may jeopardize my authorization to seek medical care at the expense of the State of New Jersey.

Employee's Signature: _____

Date: _____ Time: _____

ATTN.: Human Resources Unit
Employer: _____

Address:
_____

Telephone: _____

Fax No.:
_____

Received by:

Human Resources Representative (Print): _____

Signature: _____

Date Received: _____

2/2002