San Diego Unified
SCHOOL DISTRICT

Risk Management Department
P - 858-627-7345
F - 858-627-7353

Declination of Medical Treatment

Employee Name:	Employee ID:
Date Of Injury (DOI):	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 asap.

_____ _____
Employee Signature Date/Time

_____ _____
Signature of Contact/Supervisor Date/Time

_____ _____
Print Name of Contact/Supervisor Phone Number