Fullerton School District
Offering of Medical Treatment

Instructions: Employee will review and sign this form acknowledging that medical treatment was offered.

Date Reported: _____ **Date of Injury:** _____

Employee Name: _____ **Location/School:** _____

Brief description of injury/illness:_____

_____

_____

_____

I was offered medical treatment and the DWC-1 Form for the above injury or illness. I do not feel that medical treatment is necessary at this time. I understand that if medical treatment becomes necessary, I will notify my supervisor immediately and seek treatment at a medical facility approved through the Fullerton School District's Medical Provider Network (MPN), WELLCOMP.

If my medical treatment is pre-designated and on file in Risk Management prior to this incident, I will inform my supervisor or District representative.

If I elect to seek medical treatment without advising my supervisor or without authorization from Risk Management, I understand that I may be responsible for the total cost of said treatment.

Signature: _____ **Date:** _____

District Representative: _____**Date:** _____

Completed form must be maintained in Employee Injury File