RM0002
Rev. 8/19

DECLINATION OF TREATMENT FOR WORK RELATED INCIDENT

Phone: 402-436-1760
Fax: 402-458-3276

Risk Management Department
Lincoln Public Schools
(Use Blue or Black ink)

ENTIRE FORM MUST BE COMPLETED AND RETURNED TO RISK MANAGEMENT, BOX 14

Employee Name: _____ Position: _____ Special Ed: ❑ Yes ❑ No

Date of Incident: _____ Time of Incident: _____ Employee ID# ___ ___ ___ ___ ___ ___ ___ ___

Dept.: _____ Phone: _____ LPS Email: _____

Building Where Employed: _____ Work Phone: _____

Location Where Incident Occurred: _____

Cause of Incident: _____

Did incident involve a student?: ❑ Yes ❑ No Student ID#/Name: _____ Special Ed. Student: ❑ Yes ❑ No

Body Part(s) Affected: _____

1. Resulting Complaints _____

2. Describe why you do not believe you need any medical treatment:

_____

_____

_____

COMPLETION OF THIS FORM DOES NOT PRECLUDE YOU FROM SEEKING TREATMENT

I decline treatment and choose not to file a Workers' Compensation claim at this time for the above described incident for the reason(s) stated above. Also, this incident resulted in no time away from work, restricted work, loss of consciousness, or medical treatment other than first aid.

I understand that if any pain or other symptom persists for more than one week, I will:

1. **Contact the Risk Management Office**
2. **Complete a Workers' Compensation Employee Accident Report Form**
3. **Seek medical attention upon direction from Risk Management**

_____ _____

(Non-Electronic) Employee Signature *Date*

_____ _____

(Non-Electronic) Supervisor Signature *Date*

DO NOT USE THIS FORM FOR BLOODBORNE RELATED INJURIES.

SEND FORM TO RISK MANAGEMENT, BOX 14, LPSDO, WITHIN 24 HOURS OF INCIDENT

Risk Management Use Only