RM0002
Rev. 11/26

DECLINATION OF TREATMENT FOR WORK RELATED INCIDENT

Risk Management Department
Lincoln Public Schools

Employees must complete the form if you are <u>not seeking medical attention</u> due to work related injury.

EMPLOYEE INFORMATION

Employee ID# _____ First Name: _____ M.I.: _____ Last Name: _____

Building Where Employed: _____ Department: _____

Position: _____ Special Education: ❑ Yes ❑ No

LPS Email: _____ Cell Phone: _____ Work Phone: _____

INCIDENT INFORMATION

Location: _____ Date: _____ Time: _____

Location Description: _____
(e.g. Room Number, Vehicle Accident Location, Playground, North Parking Lot, etc.)

Incident Description:

Student Involved?: ❑ Yes ❑ No Student Name: _____ Student ID#: _____

Special Education Student: ❑ Yes ❑ No **AND/OR** Early Childhood?: ❑ Yes ❑ No

Body Part(s) Affected: _____
(e.g. Left Foot, Right Arm, Lower Back, etc.)

Resulting Complaints: _____

Describe below 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.

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

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

_____ _____
Employee Signature *Date Signed*

_____ _____
Supervisor / Principal Signature *Date Signed*

DO NOT USE THIS FORM FOR BLOODBORNE EXPOSURES

Risk Management Dept. • Phone: 402-436-1760 • Fax: 402-458-3276