Date _____

Work Comp Declination of Medical Treatment

Employer Information

Employer: _____

Treatment Authorized by: _____

Title: _____

Telephone Number: _____

Injured Employee Information

Employee: _____ Social Security Number: _____

Job Title: _____

Department: _____ Location: _____

Date of Injury: _____ Body Part Injured: _____

Work Comp Insurance Carrier: Missouri Employers Mutual Insurance: 1.800.442.0593

Treatment Declination

I am ***declining*** my employer's offer of authorized medical treatment to cure and relieve the effects of the injury I am claiming to have sustained at work on _____ [insert date]. I understand that by declining my employer's offer of medical care, any treatment I obtain on my own will be at my own expense.*

I also understand that if I reconsider and am interested in receiving authorized medical care, I must advise my employer as soon as possible.

Employee Signature _____ Date _____

* *If the employee desires, he shall have the right to select his own physician, surgeon, or other such requirement at his own expense. Section 287.140.1*

REMARKS _____

_____

Submit completed form to:

Missouri Employers Mutual Insurance
P.O. Box 1810, Columbia, MO 65205

Fax: 1.800.442.0597

Email: claims@mem-ins.com