SAFETY AND RISK MANAGEMENT
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Atlanta, GA 30302-3966
Phone: 404/413-9545
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Georgia State University

ACCEPTANCE / DECLINATION OF MEDICAL TREATMENT FOR AN ON THE JOB INJURY / ILLNESS

Date: _____

To: Department of Administrative Services, Workers' Compensation Unit

Co: Benefits Office of Human Resources, Georgia State University

From: Georgia State University, Department of Safety and Risk Management

Re: Employee Acceptance/Declination of Workers' Compensation Benefits

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On the date of _____, I, _____, was injured on the job while working for the Department of _____ at Georgia State University.

Please choose **ONE** of the following two options and ***initial*** on the appropriate line:

_____ I **DO NOT** want medical treatment for my injuries at this time. I understand that I may change my mind at any time within 30 days of my reported accident date by contacting the Department of Safety and Risk Management.

_____ I **DO** want medical treatment for my injuries at this time. I am requesting that a Workers' Compensation Claim be filed so that I may select a physician to treat my injuries.
Note: If this selection is made, employee must initial the statements below.

Once my Workers' Compensation Claim is filed I understand that I must:

_____ Schedule a doctor's appointment before returning to work.

_____ Keep all scheduled doctor's appointments or reschedule them.

_____ Provide my Supervisor AND the Department of Safety and Risk Management with a doctor's work status note ***each time*** I see a medical professional for my injuries.

_____ _____
Signature of Employee (as shown on payroll) Date Signed