SANTA MONICA COLLEGE
RISK MANAGEMENT DEPARTMENT

DECLINATION OF WORKERS' COMPENSATION BENEFITS

RE: EMPLOYER: **Santa Monica College**
EMPLOYEE:
DATE OF INJURY:
CLAIM NO: **N/A**
OUR FILE NO: **N/A**

I HAVE BEEN ADVISED OF, AND UNDERSTAND, MY RIGHT TO WORKERS' COMPENSATION BENEFITS, WHICH INCLUDE TEMPORARY DISABILITY, PERMANENT DISABILITY AND MEDICAL TREATMENT.

I AM NOT PURSUING WORKERS' COMPENSATION BENEFITS FOR THE INCIDENT WHICH OCCURRED ON_____.
(DATE OF INCIDENT)

I HAVE BEEN OFFERED AN EMPLOYEE'S CLAIM FORM AND I HAVE DECLINED A MEDICAL EVALUATION AND AM HEREBY WAIVING ANY RIGHTS I MAY HAVE TO WORKERS' COMPENSATION BENEFITS FOR THE ABOVE-STATED DATE OF INCIDENT.

_____
Print Name

_____ _____
Signature Date