LOS ANGELES COMMUNITY COLLEGE DISTRICT
DEPARTMENT OF FACILITIES PLANNING AND DEVELOPMENT
SUSTAINABLE BUILDING PROGRAM

OCIP DECLINATION FORM

Declination of Medical Examination/Treatment

GENERAL INFORMATION

Name: ______________________________

Firm Name: ______________________________

College: ______________________________

Date of Incident/Accident: ____________________ Time of Incident/Accident: ____________________

Description of Incident/Accident:

DECLINATION ACCEPTANCE

Please initial the appropriate paragraph

__________ My signature below confirms that I AM NOT experiencing any signs or symptoms resulting from the incident/accident described above. Medical treatment has been offered to me; however, I decline any medical evaluation or treatment as a result of this job-related incident/accident.

__________ My signature below confirms that I AM experiencing signs or symptoms resulting from the incident/accident described above. Medical treatment has been offered to me; however, as I feel my symptoms are improving, I decline any medical evaluation or treatment as a result of this job-related incident/accident.

If the need for medical treatment arises as a result of this incident/accident, I have been instructed to inform my supervisor immediately.

Signature: ______________________________ Date: ____________________

Contractor Safety Representative:

Name (Print): ______________________________

Signature: ______________________________ Date: ____________________