Diocese of San Jose

Human Resources

Employee's Waiver of Medical Attention Form

Workers' Compensation

Parish/School Information	
Location Name:	Location #
Location Address:	Telephone:
Contact Name:	Facsimile:
NOTICE TO ADMINISTRATORS/SUPERVISORS: THIS FORM MUST BE COMPLETED AND SUBMITTED ALONG WITH THE DSJ SUPERVISOR'S ACCIDENT INVESTIGATION REPORT AND THE 5020 COMPENSATION CLAIM FORM TO THE HUMAN RESOURCES DEPARTMENT WHEN AN EMPLOYEE DECLINES MEDICAL ATTENTION. *MAIL TO: 1150 NORTH FIRST STREET #100, SAN JOSE, CALIFORNIA 95112. TELEPHONE: 408-983-0149, FAX 408-983-0203.*	
Employee Personal & Work Information	
Employee Name:	Telephone:
Home Address:	E-mail Address:
Position/Title:	SSN:
Supervisor Name:	Telephone:
Employee Injury Information	
Date of Injury:	Type of Injury:
Location Where Injury Occurred:	
Description of How Injury Occurred:	
Waiver Authorization	
I UNDERSTAND THAT AS AN EMPLOYEE OF THE DIOCESE OF SAN JOSE, I AM ENTITLED TO RECEIVE MEDICAL ATTENTION WHEN I SUSTAIN AN INJURY OR ILLNESS ON THE JOB. I HAVE COMPLETED AND SUBMITTED AN OSHA EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS FORM (OSHA FORM 5020). AT THIS TIME I DO NOT WISH TO SEEK MEDICAL ATTENTION FOR THE INJURY/ ILLNESS I SUSTAINED ON THE DATE INDICATED ABOVE. I UNDERSTAND THAT IF I DECIDE TO SEEK MEDICAL ATTENTION AT A LATER DATE DUE TO THIS INJURY (WITHIN ONE YEAR FROM THE ACTUAL INJURY DATE), I CAN BE TREATED BY A DIOCESAN AUTHORIZED PHYSICIAN WITHIN THE MANAGED PROVIDER NETWORK (MPN).	
Employee Signature:	Date Signed:

Human Resources Only	
Form Received By :	Date Received: