DATE _____



Work Comp Declination of Medical Treatment

EMPLOYER INFORMATION	DN
Employer:	
Treatment Authorized b	oy:
Title:	
NJURED EMPLOYEE IN	FORMATION
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
REATMENT D ECLINATION	DN
effects of the injury I am cl I understand that by declin on my own will be at my	reconsider and am interested in receiving authorized medical care,
Employee Signature	Date
such requirement at his	he shall have the right to select his own physician, surgeon, or othe own expense. Section 287.140.1
bmit completed form to:	Missouri Employers Mutual Insurance P.O. Box 1810, Columbia, MO 65205
	Fax: 1.800.442.0597

Email: claims@mem-ins.com