County of Riverside
Human Resources Department, Worker's Compensation Division
P.O. Box 1120, Riverside, CA 92502-1120
Stop #2180
(951) 955-3530

INDUSTRIAL INJURY MEDICAL SERVICE ORDER

To Doctor ____________________

Address ____________________

Please call the above office prior to, and after rendering medical treatment to the following employee in accordance with the terms of the Worker's Compensation laws. Complete and mail timely a Doctor's First Report of Occupational Injury or Illness to the above address.

Full Name of Employee: ____________________

Dept. Name: ____________________

Employee number: __________ Date of Injury: __________ Time: __________

Dept #: __________ Fund #: __________ Organization #: __________

Occupation: ____________________

Authorized By: __________ Title: __________

Date: ____________________

White-Doctor, Yellow-Worker's Compensation, Pink-Department/Division

Declination Statement

I have declined the offer for medical treatment for the injury as follows:

Date of Injury: __________ Time: __________

How did the Incident occur: ____________________

____

____

Part of Body Affected: ____________________

Reason for declination: ____________________

Dept #: __________ Fund #: __________ Organization #: __________

Occupation: ____________________

PRINT FULL NAME: ____________________

SIGN FULL NAME: ____________________

DATE: ____________________