



SAN JOAQUIN COUNTY
EMPLOYEE REQUEST for MEDICAL TREATMENT

TO: Doctor _____

Doctor's Address _____

_____, while in our employ
(Employee)

is requesting medical treatment for incident occurring

(Date) (Time)

A Workers' Compensation claim has been filed. Please complete and send the "Doctor's First Report of Work Injury" to San Joaquin County Human Resources, Risk Management, 44 N. San Joaquin Street, Suite 330, Stockton CA 95202.

FROM: EMPLOYER San Joaquin County

DEPARTMENT: _____

ADDRESS: 44 N. San Joaquin Street, Suite 330, Stockton CA 95202

BY: _____
(Supervisor) (Date)

OR: **"I have declined the offer of professional medical treatment at this time"**

(Employee's Signature) (Date)