REQUEST TO WITHDRAW CLAIM FOR WORKER'S COMPENSATION BENEFITS

NAME: _____
First Middle Last

ADDRESS: _____
Number Street City/State

BIRTHDATE: _____ SOCIAL SECURTITY #: _____

EMPLOYER: _____

DATE OF INJURY: _____ Claim #: _____

REPORTED TYPE OF INJURY: _____

_____

I hereby request to withdraw my claim for Workers' Compensation benefits related to this injury. By signing this form, I understand this claim will be closed and I will not be entitled to Workers' Compensation benefits for this reported injury. This injury is not work related, or I am requesting to withdraw and close this claim for the following reason: _____

_____

I am making this request of my own free will. I have not received any threat or promise from my employer, the insurance carrier, their agents or any other person to induce me to withdraw this claim.

DATED THIS _____ DAY OF _____, _____ AT
Day Month Year

_____, _____, _____ .
City County State

I HEREBY SWEAR UNDER PENALTY OF PERJURY OF THE LAWS OF THE STATE OF CALIFORNIA THAT THE FOREGOING IS TRUE AND CORRECT.

_____
Signature