

**WAIVER OF OCCUPATIONAL DISEASE COVERAGE UNDER
THE VIRGINIA WORKERS' COMPENSATION ACT**

Pursuant to the provisions of §65.2-407 of the Virginia Workers' Compensation Act, the undersigned hereby waives the right to claim compensation benefits covering the following physical conditions:

This _____ day of _____ 20 _____

Witness: _____

Employee

Address

Approved by the Virginia Workers'
Compensation Commission

on _____ 20 _____

Employer

PHYSICIAN'S CERTIFICATION

It is my opinion that the named employee is affected by or is susceptible to:

since history and physical examination indicate:

In view of the nature of employment conditions inherent in the operations of:

Name of employer: _____

I have advised the employer of my opinion so that a waiver may be submitted to you for approval.

_____, 20____, _____, M.D.