**Workers Compensation Waiver Form**

**Employee Information
Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Waiver Agreement
☐ I acknowledge that I am waiving my rights to file a workers' compensation claim under specific circumstances as outlined in state laws.
☐ I understand that this waiver does not impact my right to file a claim for any future work-related injuries.
☐ I voluntarily sign this waiver with full understanding.**

**Reason for Waiver
☐ Independent Contractor
☐ Volunteer Work
☐ Executive Exemption
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employee Declaration
I confirm that I have read and understood this agreement.**

**Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_
Employer Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_**