**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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_**