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 _____ 19 _____

Witness: _____

_____
Employee

_____
Address

Approved by the Virginia Workers' Compensation Commission

_____

on _____ 19 ___

_____
Employer

VWC Form No. 9A (rev. 10/1/91)

(See reverse for physician's statement)

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.

_____19 ____ _____, M.D.