The Form Must Be Original & Completed In Pen

FORM I-11

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

Division of Workers' Compensation

220 French Landing Dr.
Nashville, Tennessee 37243-1002

NOTICE OF WAIVER BY EMPLOYEE FOR BENEFITS PROVIDED BY THE TENNESSEE WORKERS' COMPENSATION LAW IN CLAIMS ARISING OUT OF OCCUPATIONAL DISEASES

I,_____, an Employee
(Employee or prospective employee)

Of

_____
Business Name FEIN #

_____
Business Address

_____
Business Address

hereby give written notice to the Tennessee Workers' Compensation Division that I have received medical advice that I am affected by or susceptible to

_____
Name of Disease

an occupational disease as defined in Section 50-6-301 of the Tennessee Code Annotated and wish to waive any and all claims for benefits either for myself or for anyone else claiming by or through or on account of me which may arise in the future on account of the aforesaid disease. Copy of medical statement with Doctor's signature in pen, verifying that I am affected by or susceptible to the named disease, is attached.

_____
Employee's signature

_____
Social Security Number

_____
Business Address

_____
Business Address

Dated this _____day of_____, 20_____.