**South Carolina Workers' Compensation Commission**
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5675

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ SSN: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Preparer's Name: _____ Law Firm: _____

Employer's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Insurance Carrier: _____
Preparer's Phone #: _____

## Occupational Disease Waiver

The undersigned applicant does hereby waive my right to make a claim for compensation for the occupational disease indicated while employed by the above employer. I understand my right to waive liability for the above-named disease as provided for in Section 42-11-80 and Regulation 67-1002 of the South Carolina Workers' Compensation Law, which reads in part:

> "If an employee who had previously suffered from an occupational disease desires to continue in an employment to which such a disease is a hazard, he may waive his right to receive further benefits for disablement or disability from such disease by written agreement approved by the Commission in accordance with such rules as it may promulgate."

***Therefore, it is my understanding that I only waive my right to receive compensation for the above-named disease and still retain all other rights given an employee under the South Carolina Workers' Compensation Law.***

_____ _____
Applicant Name | Applicant Signature/Date

_____ _____
Employee's Legal Representative Name | Signature of Claimant or Legal Representative/Date

_____ _____
Witness Name | Witness Signature/Date

_____ _____
Approving Commissioner's Name | Signature of Approving Commissioner/Date

Employee's representative must complete and file Form 65 and physician's statement (per R.67-1002) with the Judicial Department.