Ohio | Bureau of Workers' Compensation

Waiver of Workers' Compensation Benefits for Recreational or Fitness Activities

Instructions

- Complete this form to waive workers' compensation coverage for voluntary participation in employer-sponsored recreational activities or fitness programs.
- In the space provided, list all employer-sponsored recreational activities and fitness programs for which the employee wishes to waive workers' compensation coverage. Make a line through any blank spaces.
- The employee **must** sign and date this form to acknowledge agreement.
- The employer shall retain the original for his or her files and provide a copy to the employee.
- The employer should submit a copy to BWC **only when an employee files a claim** for an injury or occupational disease sustained in the employer- sponsored recreational activity or fitness program. For further information call 1-800-644-6292.

Employee name (please print or type)	Date
Employer name	Risk number

Pursuant to Section 4123.01(C)(3) of the Ohio Revised Code (ORC), the employer and employee shall list those employer-sponsored recreational activities and fitness programs for which the employee wishes to waive all rights to compensation and benefits under Chapter 4123 of the ORC. The waiver must be signed and dated prior to the date of injury or, in an occupational disease claim, the date of disability. Should an employee sustain an injury or occupational disease in an employer-sponsored recreational activity or fitness program **which is not listed**, the employee may be eligible for workers' compensation benefits.

Recreational activities/Fitness programs

_____

_____

_____

_____

_____

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The undersigned declares that he or she is a voluntary participant in the employer-sponsored recreational activities or fitness programs listed above. He or she hereby waives and relinquishes all rights to workers' compensation benefits under Chapter 4123 of the ORC for any injury or disability incurred while participating in the above activities or programs. This waiver is valid for two calendar years. The waiver may not bar any workers' compensation claim filed for death benefits by the employee's dependents.

_____ _____

Employee signature Date signed

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