Ohio | Bureau of Workers' Compensation

Waiver of Examination
Statewide Disability Evaluation System

•The employer should sign and date the form.

Injured worker name	Claim number

The employer or BWC has waived the medical examination, which Section 4123.53 (B) of the Ohio Revised Code requires after 90 consecutive days of temporary total disability compensation. The employer or BWC has waived the exam

☐ Temporarily or ☐ Permanently for the following reason:

☐ Injured worker remains hospitalized;
☐ Injured worker is scheduled for surgery;
☐ Injured worker is scheduled to return to work on;

_____

☐ Other_____

_____.

Waiver authorized by:

Employer name	Date
Employer representative	Title

☐ Requested follow-up examination date:_____

☐ The BWC nurse has recommended to waive the examination.

Signature of self-insured employer or BWC nurse completing form

Signature	Date

BWC use only

☐ BWC has approved the request for waiver.

☐ BWC has denied the request for waiver for the following reasons: _____

_____

_____

Signature	Date

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