



**\*The Form Must Be Original & Completed In Pen\***

**FORM I-12**

**TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT**

**Division of Workers' Compensation**

220 French Landing Drive  
Nashville, Tennessee 37243-1002

**NOTICE OF WAIVER BY EMPLOYEE FOR BENEFITS PROVIDED BY THE  
TENNESSEE WORKERS' COMPENSATION LAW FROM INJURIES RESULTING FROM  
EPILEPSY**

As provided in Tennessee Code Annotated, Section 50-6-213, notice is hereby given that

\_\_\_\_\_ (Employee or prospective employee)

of \_\_\_\_\_  
Business Name FEIN # :

\_\_\_\_\_  
Business Address

\_\_\_\_\_  
Business Address

hereby gives written notice to the Division of Workers' Compensation, Tennessee Department of Labor, of his waiver of compensation benefits for any injuries sustained during the course of employment which are the result of any epileptic seizure. This election does not effect benefits due for any other reason. This election is not effective until a copy is filed with the Division. Copy of medical statement with Doctor's signature in pen, giving prior history of epilepsy, is attached hereto. An election may be revoked by giving written notice to the employer of revocation, and such revocation shall be effective upon filing a copy of such notice with the Division of Workers' Compensation.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Social Security Number

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.