



**Bureau of Workers'
Compensation**

Employer's Waiver of 90 Day Examination

Claim number(s)

Injured worker information

Name

Waiver information

The "90 Day Exam" is a medical examination of the injured worker that is generally done after 90 consecutive days of temporary total disability compensation has been paid. As the employer of the injured worker, I am authorizing waiver of the medical examination for the following reason(s).

- ☐ Injured worker remains hospitalized.
- ☐ Injured worker has just been released from the hospital and is home recovering.
- ☐ Injured worker is scheduled for or is recovering from surgery.
- ☐ Injured worker has been referred for vocational rehabilitation or is actively participating in a vocational rehabilitation plan.
- ☐ Injured worker appears to be on track to return to work and an exam does not appear to be necessary at this time.
- ☐ Injured worker is scheduled to return to work on _____.
- ☐ Other (please explain) _____

My waiver of this exam is (please check one):

☐ Permanent ☐ Temporary ☐ Requested follow-up examination date: _____

Employer/employer representative signature

Print name	Title
Signature	Date

☐ I am a non-attorney representative for the employer who is signing at the direction of the employer.