

REQUEST FOR CLAIMS FILE INFORMATION/PRIOR CLAIMS

Please complete this form and return it to the following address, together with all appropriate documents and a pre-addressed stamped envelope. **This request will NOT be processed if the self-addressed stamped envelope is not provided.** Applicable search fees (\$1 per search conducted) and copy charges apply.

WORKERS' COMPENSATION COMMISSION
Attention: Records Department
1915 N. Stiles Avenue
Oklahoma City, OK 73105

Please indicate the TYPE of search you are requesting (please type or print):

<input type="checkbox"/> By Name <hr/> First Name <hr/> Last Name	<input type="checkbox"/> By Name and the LAST 4 DIGITS of the Social Security Number (Authorization from the holder of the Social Security Number is required.) <hr/> First Name Last Name <hr/> I authorize the use of my Name and the LAST 4 DIGITS of my Social Security Number to search for workers' compensation information as evidenced by my signature below: Signature of SSN Holder: <hr/> Date Social Security #: LAST 4 DIGITS ONLY XXX-XX-_____
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I declare under **PENALTY OF PERJURY** that the information sought hereby is not for a purpose in violation of any state or federal law. I understand that I am required by law to disclose the person for whom this search request is being made, if different from myself.

This search is being made on behalf of the following:

Name: _____

Address : _____

City: _____ State: _____ Zip Code: _____

Please indicate your information below (the preparer of this form):

Preparer's Signature		Preparer's Printed Name:		
Telephone #	Address:	City:	State:	Zip Code:

This document is considered a public record under Oklahoma law.