## 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 COURT
    of EXISTING CLAIMS
    1915 N. Stiles Avenue, Suite }12
    Oklahoma City, OK 73105-4918
        (405) 522-8600
```



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

| $\square$ By Name | By Name and the LAST 4 DIGITS of the Social Security Number (Authorization from the holder of the Social Security Number is required.) |  |
| :---: | :---: | :---: |
| First Name | Fist Name | Last Name |
| Last Name | 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: |  |
|  | Siganaure of SN Holder: |  |
|  | Date | Social Security \#: LAST 4 DIGITS ONLY XXX-XX- |

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: $\qquad$
Address : $\qquad$
City: $\qquad$ State: $\qquad$ Zip Code: $\qquad$

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

| Preparer's Signature | Preparer's Printed Name: |  |  |  |
| :--- | :--- | :--- | :--- | :--- | :--- |
| Telephone \# | Address: | City: | State: |  |

This document is considered a public record under Oklahoma law.

