

Please return this form to the address listed below along with all appropriate documents and a self addressed stamped envelope:

Oklahoma Workers' Compensation Court  
1915 N. Stiles Ave.  
Attn: Records Department  
Oklahoma City, OK 73105

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Fold along dotted line. Place in a window envelope so that the address appear.

Re Workers' Compensation  
Claim of: Claimant's Name

Last: \_\_\_\_\_ First: \_\_\_\_\_

**REQUEST FOR CLAIMS FILE INFORMATION/PRIOR CLAIMS**

By name or  By Social Security # (Requires authorization from holder of Social Security Number)

I authorize the use of my social security number to search for workers' compensation claim information:

Signature of SS# holder: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_\_\_

I declare under **PENALTY OF PURJURY** 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 for:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Your Signature:		Printed Name:		
Telephone#:	Address:	City:	State:	Zip Code: