

Please return this form to the address listed below along with all appropriate documents and a self addressed stamped envelope. Please note: This request will not be processed if the self-addressed stamped envelope is not provided.

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

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

REQUEST FOR CLAIMS FILE INFORMATION/PRIOR CLAIMS

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

<input type="checkbox"/> By Name
First Name
Last Name

<input type="checkbox"/> By Social Security Number (Requires Authorization from holder of Social Security Number as evidenced by signature below)	
First Name	Last Name
I authorize the use of my social security number to search for workers' compensation information as evidenced by my signature:	
Signature of SS# Holder:	
Date	Social Security #:

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):

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.

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