



Workers' Compensation Form
Pennsylvania Workers' Compensation History Request Form

Candidate Name: _____

Candidate Address: _____

Social Security Number: _____

Date of Birth: _____

I authorize Verified Credentials, Inc. to contact the *Pennsylvania Workers Compensation Records Department* to release information regarding my claim history for the purpose of completing my Consumer Report.

This authorization is valid for 60 days from signature date.

Candidate Signature

Date Signed

Please forward claim history to Verified Credentials, Inc.: Verified

Credentials, Inc.
Attn: Operations
20890 Kenbridge Court
Lakeville, MN 55044

Email: operations@verifiedcredentials.com
Phone: 888.222.9095