

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 127
Oklahoma City, OK 73105-4918
(405) 522-8600**

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

<input type="checkbox"/> By 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.)
First Name	First Name
Last Name	Last Name
Last Name	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:
Last Name	Signature of SSN 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: _____

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.