MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

AUTHORIZATION TO RELEASE INFORMATION

EMPLOYER: **You must sign and date the statement below or this form will be returned to you.**

I hereby certify the information being sought by this request is being made on applicants for employment only after a conditional job offer has been made, or on current employees for a purpose which is job-related and consistent with business necessity. I further certify the information obtained in this request will not be used to discriminate in any manner against the individual who is the subject of this request on the basis to disability, in violation of the Americans with Disabilities Act of 1990. 42 U.S.C. §12101 et seq.

Date _____ *Employer's Signature* _____

To be completed by EMPLOYER: ***(Black ink only or 10 pitch font or greater)***

Employer's Full Name

Employer's FEIN

Employer's Street Address

Employer's City, State, Zip Code

EMPLOYEE: **For you to release this information with this form, you must be an employee or have received an offer of employment.**

I hereby voluntarily authorize the Missouri Division of Workers' Compensation to release information to my employer. The information to be released shall only include information generated by computer search and shall not include any copies of documents which may be in the Division's possession. I understand this authorization will include release of information covering both pending and closed cases involving any work related injuries on file with the Division.

Date _____ *Employee's Signature* _____

To be completed by EMPLOYEE: ***(Black ink only or 10 pitch font or greater)***

Employee's Full Name

Employee's Social Security Number

Employee's Street Address

Employee's City, State, Zip Code

Subscribed and sworn before me, by _____ (employee) in my presence, this _____ day of _____, _____, a Notary Public in and for the State of Missouri.

My Notary Commission expires _____, _____. _____

(Signature of Notary Public)

Submit form and fee to: **DIVISION OF WORKERS' COMPENSATION RECORD SEARCH**
PO BOX 58
JEFFERSON CITY, MO 65102-0058

If you have questions,
call 1-888-837-6069
DIVISION DOES NOT ACCEPT FAXES

The information provided pursuant to this request is not to be used in a manner which would violate the Americans with Disabilities Act (ADA). For more information about the Americans with Disabilities Act (ADA), contact the ADA Project-UMC, Region VII DBTAC, 100 Corporate Lake Drive, Columbia, MO 65203 or call 1-800-949-4ADA (4232).