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

- -

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:

Rev.12/05

This document is considered a public record under Oklahoma state law.