

Requisition for Workers' Compensation File – Exempt Requestor

Workers' Compensation Agency File #: _____ Date: _____

In Re Workers' Compensation Claim of: Claimant's Name LAST: _____

FIRST: _____

- For Review/Copy
- To Administration
- To Judge _____
- To Docket Office
- To Court Reporter
- To Health Services Division
- To Counselor Division
- To Other _____

Reason _____

NOTICE: Do Not Remove Files From Building

Requestor must review and sign the reverse side of this Requisition

Created 2-1-14

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STATEMENT OF EXEMPTION

By signing below, the undersigned represents and acknowledges as follows: That the undersigned meets the requirements of an exemption defined by the workers' compensation laws of this state, as indicated below; That the information sought will not be used for any non-exempt purpose. Please circle the number referencing the exemption that applies.

1. Requests made by a public officer/employee in the performance of governmental duties, or as allowed by law;
2. Requests made by an insurer, self-insured employer, third-party claims administrator, or a legal representative thereof, when necessary to process or defend a workers' compensation claim;
3. Requests made by a worker or worker's representative for th worker's claim information;
4. Disclosures made for educational or research purposes, in such a manner that the disclosed information cannot be used to identify any worker who is the subject of a claim;
5. Requests made by a health care or rehabilitation provider, or legal representative thereof, when necessary to process payment for services rendered to a worker.

Signature

Printed Name:

Street Address

City/State/Zip

Phone Number

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