DIVISION OF WORKERS' COMPENSATION

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

AUTHORIZATION TO RELEASE INFORMATION

NOTE: Section 287.380 (3) RSMo prohibits the Division from releasing information reported to the Division by an employer or insurer.

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 an applicant for employment only after a conditional job offer has been made, or on a current employee 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 (must be completed) *Employer's Signature*

_____

Title of Person Authorized by the Employer to Sign

To be completed by EMPLOYER: ***(Black ink only or 10 point 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 the above referenced 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 resolved by a settlement approved by an administrative law judge or Award issued by an administrative law judge.

_____ _____

Date *Employee's Signature*

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

Employee's Full Name	**Employee's Social Security Number**
Employee's Street Address	
Employee's City, State, ZIP Code	

State of _____, County (and/or City) of _____

On this _____ day of _____ in the year _____ before me, _____ (name of notary), a Notary Public in and for said state, personally appeared _____ (name of individual), known to me to be the person who executed the within Authorization to Release Information and acknowledged to me that _____ (he/she) executed the same for the purposes therein stated.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my Notarial Seal on this _____ day of _____, 20____.

My Commission expires:_____ _____

(Signature of Notary)

Affix Notarial Stamp:

NOTICE TO EMPLOYERS
WORKERS' COMPENSATION RECORDS CHECK

The Division of Workers' Compensation release authorization shall be used by your company to obtain workers' compensation records. WC-126 Authorization to Release Information must be used to submit your request. **You may submit the original or a copy of Form WC-126.** The request must be mailed or delivered to the Division of Workers' Compensation at the address below. **The Division does not accept facsimile filings.**

Section 287.380 (3) RSMO prohibits the Division from releasing information reported to the Division by an employer or insurer.

Specific instructions (The Division will reject the request if it does not comply with the following):

1. Both the employer and employee **MUST** complete the form.
2. The employer must sign and date the form. The person signing the form must be authorized to act on behalf of the employer and provide his/her title or position of the job held.
3. The Division will not provide records by facsimile transmission.
4. The Division requires an employer to provide us with a letter authorizing the Division to release the record check information to a third party that the employer has retained for purposes of obtaining the records. It is the employer's responsibility to ensure that the third party retained to obtain the records information from the Division does not misuse or secondarily rerelease the employee's information.
5. The name of the employer requesting the information should match the Federal Employee Identification Number (FEIN) number. If two employers are noted on the form, the Division will not process the form and reserves the right to return it to the employer.
6. The employer shall not use this form to compel an employee to request his/her workers' compensation records from the Division.
7. The employee shall not pay for any costs related to this records request.
8. Employee's full name (printed or typed) must be provided. **MUST** complete form in black ink or minimum of 10-pitch font. **If the employee's name has changed within the last ten (10) years, include prior name(s) along with current name.**
9. Employee must sign form and the signature must be properly notarized. The notary seal on the document must be made by a seal embosser or printed by a black ink rubber stamp with the words "Notary Seal," "Notary Public,' and "State of Missouri." A notarized signature by a notary public commissioned in another state is acceptable as long he or she meets the requirements of that state's laws governing Notaries Public.
10. Social Security Number must be included and must be legible.
11. Employer FEIN must be provided.
12. **MUST** enclose a self-addressed, stamped envelope for return information.
13. Records search fee – $5.00 per individual.
14. Signature date of employee and notary must match and be within 60 days of the date of the request.
15. When ten (10) or more forms are sent at one time, include a legible list of employees' names, in alphabetical order, along with their social security numbers.
16. Forms that are illegible and cannot be reproduced in the Division's image system will be returned.

Records are searched from January 1986 through present. If a search is requested for records prior to 1986, past employers' names are required. A computer printout will be sent for records from January 1986 through present.

The request must be accompanied by payment. ***NO CASH.*** We will accept a company check or money order made payable to: **DIVISION OF WORKERS' COMPENSATION**.

The request and payment must be mailed to:

Division of Workers' Compensation Record Search
P.O. Box 58
Jefferson City, MO 65102-0058
800-775-2667

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 ADA, you may contact the Great Plains ADA Center, 100 Corporate Lake Drive, Columbia, Missouri 65203 or call 1-800-949-4ADA (4232).

Please do not contact the ADA Center with questions about this form or send the form to them.

The Privacy Act of 1974, as amended, and the Deficit Reduction Act require notification because you are being asked to furnish your Social Security Number (SSN).