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).

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 fax filings.**

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. Full name (printed or typed). **MUST** complete form in black ink or minimum of 10-pitch font. **If the person's name has changed within the last ten (10) years, include prior name(s) along with current name.**
3. Employee must sign form and the signature must be properly notarized. The notary seal on the document **must** be 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 as he or she meets the requirements of that state.
4. Social Security Number must be included and must be legible.
5. Employer Federal Employee Identification Number (FEIN) must be provided.
6. **MUST** enclose a self-addressed, stamped envelope for return information.
7. Records search fee – $5.00 per individual.
8. Signature date of employee and notary must match and be within 60 days of the date of the request.
9. 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 number.
10. 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, for no additional charge.

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 fee must be mailed to:

Division of Workers' Compensation Record Search
Post Office Box 58
Jefferson City, MO 65102-0058
1-888-837-6069

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