

Iowa Workers Compensation Release Instructions

1. Applicant / Employer must fill out top portion of release:

- Name
- SSN
- DOB
- Address
- Employer Name
- Employer Address
- Date(s) of Injury if Known

2. Applicant must fill out final portion of release:

- "Signed at _____ this _____ day of _____, 20____."
(City, State)
- _____
(Print Name) Employee (Signature)
- SSN
- DOB
- Address
- Telephone Number

3. Release can be faxed or e-mailed (in PDF format) to Applicant Insight.

COPY/INFORMATION REQUEST

PLEASE USE THIS FORM TO REQUEST COPIES OF WORKERS' COMPENSATION FILES

EMPLOYEE NAME (INCLUDE MIDDLE INITIAL OR NAME)	EMPLOYEE SOCIAL SECURITY NUMBER	BIRTH DATE
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EMPLOYEE ADDRESS

EMPLOYER NAME(S)

EMPLOYER ADDRESS

DATE(S) OF INJURY/File number(s) if known

A COPY OF THE FOLLOWING PORTIONS OF THE FILE/RECORD IS REQUESTED:

Contested case pleadings, motions, settlement applications and the resulting decisions, ruling, or orders are public records. First reports of injury, subsequent reports of injury and other information that is filed as a result of an employee's injury or death and that allows identification of the employee or the employee's dependents is confidential information that may not be disclosed without a waiver by the employee except under limited circumstances. Iowa Code section 86.45

- I request only public records
- A waiver signed by each person whose records are sought is provided.
- I am entitled to the confidential information under section 86.45(2)(_____).
- Screen prints are acceptable.

Delivery Method:

- Mail (A stamped, self-addressed envelope is required.)
- Pick up Fax - (800) 261-7236
- Call for pick up ()- _____

In addition to the above requested injury date, search:

- Approximately the past 5 years**
- 10 to 15 years**
- I agree to pay the search fee of \$24 per hour, with a minimum fee of \$6 and a copy fee of \$.10 per page over the first 10 pages.
- Contact me before proceeding further if the search fee reaches \$ _____ or if the copy fee will exceed \$ _____

****These files are ordered from state records center and may take 3 to 4 weeks to retrieve.**

Send to: Larry Thomsen

Firm or Company: APPLICANT INSIGHT

Mailing Address: 5396 SSCHOOL ROAD, New Port Richey FL 34652

Telephone Number: () 800-245-2318

Charge to Account Number: 8460

Bill my firm (an advance deposit for the full amount is requested before copies are released.)



Waiver for Release of Records

I, the undersigned employee, authorize the Iowa Division of Workers' Compensation to release to:

APPLICANT INSIGHT

(Name of authorized recipient)

the categories of confidential records that are checked below, that are in the division's custody and that contain information that identifies me.

- All confidential records of any nature
- First Reports of Injury (FROI) (screen prints) filed within the past ____ years
- Subsequent Reports of Injury (SROI) (screen prints) filed within the past ____ years
- Evidence received in a contested case hearing
- The transcript from a contested case hearing
- Other (describe specific records to release) _____

Signed at _____ this ____ day of _____, 20____.
(City, State)

(Print Name) Employee (Signature)

To identify me and calls to verify that I signed this waiver, I provide my:

Social security number: _____

Date of Birth: _____

Address: _____

Telephone number: _____

14-0169 (7-05)

