

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 dashed line. Place in a window envelope so that the address appears.

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: Edge Information Management, Inc - c/o Bonnie Dowdy
Address: 100 Rialto Place, Suite 800
City: Melbourne State: Florida Zip Code: 32901

Your Signature:		Printed Name: Bonnie Dowdy, Operations		
Telephone#: 800-725-3343 x3415	Address: 100 Rialto Place, Suite 800	City: Melbourne	State: Florida	Zip Code: 32901