WORKERS' COMPENSATION RECORDS REQUEST FORM

Mail completed form to:
Louisiana Works
OWCA Records Management Section
1001 N. 23rd Street
P.O Box 94040
Baton Rouge, LA 70804-9040
Telephone No.: 225-342-7565

Status of your records request: (Office use only.)
- ☐ **Will be processed.**
- ☐ **Is being returned. *See Section III, Page 2*.**
- ☐ **Has been processed. You owe a copying fee, *See Section III, Page 2*.**
- ☐ **Is complete. *See Section III, Page 2*.**

Note: Copies of documents provided through this request shall adhere to the provisions of La. R.S. 23:1020.1, *et seq.* and La. R.S. 44:1, *et seq*., which limits the inspection and copying of workers' compensation records. ***A $25.00 fee is required per employee search. (Exception: Requests for LWC-WC-1002 will NOT be assessed a $25.00 search fee.) Copying fees are $0.25 per page.** Make all checks payable to the ***OWCA Administrative Fund***.

SECTION I: TO BE COMPLETED BY REQUESTOR

1. Select all that apply:

- ☐ I am the Employee **OR** Legal Representative of the Employee. (*Attach letter of representation*.)
- ☐ I am the Employer/Insurer **OR** Legal Representative of the Employer/Insurer. (*Attach letter of representation*.)
- ☐ I am NOT a party to a workers' compensation claim. (*Attach employee authorization, LWC-WC- 1151*.) (**Must be notarized**)
- ☐ I am a Prospective Employer. (*Attach employee authorization, LWC-WC- 1151*.) (**Must be notarized**)

2. Name of Requestor (Please Print)	**3. Phone Number**
4. Company Name (If Applicable)	**5. Fax Number**
6. Address, City, State ZIP	**7. Email**

SECTION II: RECORDS REQUESTED

1. Employee's Name (*Please use a separate form for each employee*.)	**2. Employee's Social Security Number**
3. Identify the workers' compensation claim you are requesting : ☐ Workers' Compensation Claim Docket #_____ Date of Injury_____ ☐ **ALL** cases for this injured worker. - If known, list the Docket # and Date of Injury for each claim in the Additional Comments Section, see right. *You will be assessed a $25.00 search fee for each workers' compensation docket number.*	**Additional Comments:**

4. Additional records I am requesting:

- ☐ Notice Of Payment, Modification, Suspension, Termination or Controversion of Compensation or Medical Benefits (LWC-WC-1002). *Only available to Employee or Employee Representative per La. R.S. 23:1201.1. *You will **NOT** be assessed a $25.00 search fee for this records request.*
- ☐ Other documents requested. *Please specify in the Additional Comments section*.

5. Need records certified? (If certified, you will be assessed $25.00.)
☐ Yes ☐ No

I have read and understand this form and the accompanying instructions. I certify that all information provided by me to the Office of Workers' Compensation Administration is accurate and correct to the best of my knowledge. I understand that providing false or misleading information may subject me to prosecution.

Signature of Requestor_____ **Date** _____

SECTION III: TO BE COMPLETED BY OWCA RECORDS MANAGEMENT SECTION

☐ **1. This records request will NOT be processed due to the following:**

- ☐ $25.00 Search fee not received.
- ☐ No Social Security Number/incomplete number.
- ☐ Employee Authorization form required.
- ☐ Incomplete information. Please provide:_____

*Your request will NOT be processed until the information is provided.

☐ **2. Your request has been processed.**

_____ Pages of responsive records have been found. Please submit a check in the amount of $_____ to the OWCA Administrative Fund. ***No** records will be sent until the check is received by the OWCA.

Your request has produced more than one employee claim._____ claims have been found. Please submit a check in the amount of $_____to the OWCA Administrative Fund. ***No** records will be sent until the check is received by the OWCA.

☐ **3. Your request is complete. The records search has:** ☐ No Records Found ☐ See Attached records.

Records request completed by _____ Date: _____