KANSAS DEPARTMENT OF LABOR
www.dol.ks.gov

Records for Workers Compensation Records

MAIL: Division of Workers Compensation
401 SW Topeka Blvd., Suite 2
Topeka, KS 66603-3105

FAX: (785) 296-0025

Consent to Release of Electronic Records as a Condition of Employment

I hereby verify that I have been offered employment by the individual or entity requesting my records from the Kansas Division of Workers Compensation and give the division permission to release the specified records below individual or entity:

Requestor's Name: _____

Applicant's Name: _____

Applicant's SSN: _____

Applicant's DOB: _____

Position Offered: _____

Please Mark the Type of Records You Give Permission to Release:

Injury Report Summaries [X]

Case/Docket Summaries [ ]

Actual Filings (Please Specify) [ ]

Actual Filings

_____

Signature of Worker

_____

Date