WORKERS’ COMPENSATION RECORDS REQUEST FORM

Mail completed form to:
Louisiana Workforce Commission
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.)
□ I am a Prospective Employer. (Attach employee authorization, LWC-WC-1151.)

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: __________