STATE OF VIRGINIA
WORKERS COMPENSATION COMMISSION
RECORDS DEPARTMENT

AUTHORIZATION FOR RELEASE OF INFORMATION

Claimant Name: _____
(Applicant)

Claimant SSN: _____
(Applicant Social Security Number)

Requestor Name: _____
(Employer Name)

The above referenced claimant authorizes TruDiligence access to all Virginia workers' compensation files. Claimant further acknowledges that above requestor/employer has made a conditional job offer prior to workers compensation records search. This authorization shall remain in effect for ninety days from the date of claimant's signature, unless claimant notifies the Workers' Compensation Commission in writing before such time, that claimant is revoking said authorization.

_____ _____
Claimant Date Signed
(Applicant's Signature)

Must be signed and dated by the claimant/applicant in the presence of a notary.

Notarization is required

STATE OF _____)
) ss.
COUNTY OF _____)

When using an embossed seal, please shade before faxing.

Subscribed and sworn to before me this

_____ day of _____, 20_____

by _____
(Print name of claimant)

_____
Signature of Notary Public

My commission expires:_____