



State of California Division of Workers' Compensation Public Records Act Request Form

**Routine requests should be made to your local district office.
Click [here](#) for local district office locations.**

Date received _____

Party/Representing a party

Due date _____

Not a party

(Response Due: Immediately or within 10 days from date of request)

Requester Information [Voluntary unless seeking personal or individually identifiable information]

Name	
Company	
DWC Authorization Number [Copy, Legal & Investigative Services]	
Representing	
Business Address	
Alternative Address	
City, State, ZIP Code	
Telephone (business)	
Fax	
E-Mail	

Description of Records Requested/Initial Contact with Requesting Party:

Inspection

Copying

WCAB File No.:
Injured Workers Name:
Other:

Is Request for Purposes of Pre-Employment Screening?
(If yes, DWC shall send notification letter to injured worker)

Yes No

For Requests for Personal Information or Individually Identifiable Information, state the purpose for which the information will be used and provide proof of identity and address.

Name of DWC Employee-Initial Contact: