STATE OF DELAWARE REQUEST FOR COPY OF DOCUMENT

Department of Labor
Office of Workers' Compensation (OWC)
4425 N. Market Street, 3rd Floor
Wilmington, DE 19802
Telephone: 302-761-8200
Fax: 302-736-9170

NAME OF REQUESTOR: _____ DATE: _____

BUSINESS OF REQUESTOR: _____

ADDRESS: _____

TELEPHONE NUMBER: _____ FAX: _____

EMAIL ADDRESS: _____

PARTY REQUESTOR REPRESENTS: _____

CLAIMANT'S NAME: _____

INDUSTRIAL ACCIDENT BOARD (CASE FILE) NUMBER(S): _____ _____

SOCIAL SECURITY NUMBER: _____

DATE OF ACCIDENT: _____ _____ _____

☐ ALL DOCUMENTS _____ ☐ OTHER (SPECIFY) _____

DELIVERY METHOD:

☐ VIA USPS

☐ PICK-UP

☐ VIA EMAIL *(I authorize the Office of Workers' Compensation to send my request via email)*

_____

SIGNATURE OF REQUESTOR: _____

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PROCESSED BY: _____ DATE PROCESSED: _____

- *THE ENTIRE FORM MUST BE COMPLETED, INCOMPLETED FORMS WILL CAUSE YOUR REQUEST TO BE DELAYED**
- ***MAKE CHECKS PAYABLE TO:*** **DEPARTMENT OF LABOR - INDUSTRIAL AFFAIRS**

SUBMIT