STATE OF DELAWARE
DEPARTMENT OF LABOR
DIVISION OF INDUSTRIAL AFFAIRS
OFFICE OF WORKERS' COMPENSATION
4425 NORTH MARKET STREET
WILMINGTON, DE. 19802

PHONE: (302) 761-8200
FAX: (302) 736-9170

REQUEST FOR COPY OF DOCUMENT

NAME OF REQUESTOR: ____________________________________ DATE: ________________

BUSINESS OF REQUESTOR: ____

ADDRESS: ____

TELEPHONE NUMBER: _________________________ FAX: ______________________________

EMAIL ADDRESS: ____

PARTY REQUESTOR REPRESENTS: ____

DOCUMENT(S) BEING REQUESTED & REASON FOR THE REQUEST

____

____

CLAIMANT'S NAME: ____

INDUSTRIAL ACCIDENT BOARD (CASE FILE) NUMBER: __________________________________

SOCIAL SECURITY NUMBER: ____

DATE OF ACCIDENT: ____

SIGNATURE OF REQUESTOR: ____

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