

# STATE OF DELAWARE REQUEST FOR COPY OF DOCUMENT

Department of Labor  
Office of Workers' Compensation (OWC)  
4425 N. Market Street, 3<sup>rd</sup> Floor  
Wilmington, DE 19802  
Telephone: 302-761-8200  
Fax: 302-7369170

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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- THE ENTIRE FORM MUST BE COMPLETED, INCOMPLETED FORMS WILL CAUSE YOUR REQUEST TO BE DELAYED\*