



STATE OF TENNESSEE
BUREAU OF WORKERS' COMPENSATION
 220 FRENCH LANDING DRIVE
 NASHVILLE, TENNESSEE 37243-1002
 615-253-1842 or fax 615-532-8546
WC.Claims@tn.gov

REQUEST FOR PRIOR WORK INJURY INFORMATION

This form is used to satisfy the requirement of T.C.A 50-3-702(b), which allows employers to verify the truthfulness of a job applicant concerning a possible prior work injury. NOTE: There is a \$10.00 fee for this service for each applicant named below. The Bureau will invoice the requester for the fee(s) after the records have been provided.

Employer d/b/a Name _____

Requester Name _____

Requester Direct Phone # _____ Title _____

Street Address 1 _____

Street 2 _____

City _____ State _____ ZIP _____

Please indicate the manner in which you want the invoice and search results returned to you.

Fax _____ or Email _____

Signature of Requester _____

Date _____

Job Applicant(s) Name (to be provided by the employer)	Applicant(s) SSN (to be provided by the employer)	# of Records Found (to be provided by the Bureau)