KANSAS DEPARTMENT OF LABOR
www.dol.ks.gov

REQUEST FOR WORKERS COMPENSATION RECORDS

K-WC 97 (Rev. 3-14)

MAIL: Division of Workers Compensation
401 SW Topeka Blvd., Suite 2
Topeka, KS 66603-3105

FAX: (785) 291-3430

Requestor name: ______________________ Phone: ( ) ____________

Company or Entity: ______________________ Fax: ( ) ____________

Address: ______________________

City, State, ZIP: ______________________

Worker's name: ______________________ SSN: ____________

Records sought: ☐ Accident report summaries ☐ Docket summaries ☐ Actual filings
☐ Electronic download (registered users only; if not yet registered, see form K-WC 96)

In order to acquire accident reports or medical records, the requestor **must** be in category I or II below. Specify which categories pertain to you and provide the accompanying information:

I) Are you:
- ☐ the employer of a worker seeking workers compensation benefits
- ☐ an insurance carrier with coverage of a worker seeking workers compensation benefits
- ☐ an insurance carrier's attorney/representative for the employer

Date of accident: ______________________

II) Are you:
- ☐ an employer which has made a conditional offer of employment to the individual whose records are sought
- ☐ an insurance carrier of an employer which has made an employment offer to the individual whose records are sought
- ☐ an insurance carrier's attorney/representative for the employer

Type of job conditionally offered to the individual: ______________________

The following release must be signed by the worker to whom the offer of employment was made:

I hereby verify that I have been offered employment by the individual or entity requesting my records from the Kansas Division of Workers Compensation and give the division permission to release the records specified to the individual or entity making the request.

Signature of worker: ______________________ Date: ____________

I certify that all information provided by me is true and correct to the best of my knowledge. I understand that providing false or misleading information may be a fraudulent or abusive practice under the Workers Compensation Act and may subject me to prosecution.

Signature of requestor: ______________________ Date: ____________

Federal Privacy Act Disclosure Section 7(a)(2)(B)

The mandatory requirement that Social Security numbers be included in forms filed with the Division of Workers Compensation is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, since our regulations which require its disclosure were in existence before January 1, 1975. The number is used as a means of identifying all the various records in the Division of Workers Compensation pertaining to an individual.

The use of Social Security numbers is made necessary because of the large number of applicants who have similar names and birth dates, and whose identities can only be distinguished by the Social Security number.