Send to: TEXAS DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION
7551 Metro Center Drive, Suite100, MS-92B
Austin, TX 78744

REQUEST FOR RECORD CHECK

INSTRUCTIONS: Please carefully read the instructions before completing this form. INCORRECT/INCOMPLETE FORMS WILL BE RETURNED TO REQUESTOR WITHOUT ACTION. PAYMENT MUST ACCOMPANY REQUEST FORM.

I. CLAIMANT IDENTITY. Provide the following information to identify the injured employee

Injured Employee's Name	Injured Employee's Social Security Number

II. REQUESTOR INFORMATION. Record check information will be sent to the requestor's address shown below.

Requestor		Title	
Firm Name		DWC/Adjuster Box Number (if applicable)	
Mailing Address		DWC Account Number (if applicable)	
City, State	ZIP	Telephone Number ( )	☐ Authorized Legal Representative Statement on File

III. FEES.

Record Checks are $15.00 each. ☐ Check box if Certification is requested. ($1 Additional Fee)

IV. REQUESTOR ELIGIBILITY AND NOTARIZATION. The Texas Workers' Compensation Act, Texas Labor Code, Title 5, Section 402.084, limits the release of confidential information in or derived from an employee's claim file to the categories of parties listed below. Please indicate the category of eligibility, which qualifies you to receive the information requested. Sign and complete the notarization prior to sending the request to DWC. Eligibility will be verified. *Please check one box only.*

- ☐ The employee or the employee's legal beneficiary
- ☐ The employee's or the legal beneficiary's representative (attach letter of representation)
- ☐ The employer at the time of injury. Requestor must provide injured employee's period of employment: _____ mo./yr. to _____ mo./yr.
- ☐ The Texas Certified Self-Insurer Guaranty Association established under Subchapter G, Chapter 407, if that association has assumed the obligations of an impaired employer
- ☐ The workers' compensation insurance carrier. Requestor must provide injured employee's date of injury: _____ mo./dy./yr.
- ☐ The Texas Property and Casualty Insurance Guaranty Association, if that association has assumed the obligations of an impaired insurance company
- ☐ A third party litigant in a lawsuit, in which the cause of action arises from the incident that gave rise to the injury (COPY OF PETITION AND ANSWER MUST BE ATTACHED). Requestor must provide injured employee's date of injury: _____ mo./yr.

I have read and understood this form and the accompanying instructions. I am entitled to receive the confidential employee information being requested as indicated above. I understand it is a Class A misdemeanor to unlawfully receive, publish, disclose, or distribute confidential claim information in or derived from an employee's claim file. {Texas Labor Code, Sections 402.064; 402.084; 402.086; 402.091}

Signature of Requestor _____ Date _____

State of _____ *
*
County of _____ *

Before me on the above date personally appeared, _____ , who after first being sworn, said the statements contained in this request are true.

Signed _____

Notary Public, State of _____ My Commission Expires _____

DWC FORM - 155
REQUEST FOR RECORD CHECK INSTRUCTIONS
www.tdi.state.tx.us

1. Use this DWC FORM-155 to request a history on a Texas workers' compensation claim. A record check provides the following data: the Industrial Accident Board (IAB) or Texas Department of Insurance, Division of Workers' Compensation (DWC) number; the date of injury; the employer at the time of injury; the nature of the injury; and the disposition of the claim (old law) or whether the claim is Income/Indemnity or Reportable (new law). **NOTE**: Injuries prior to 1/1/91 are IAB/old law. Injuries on or after 1/1/91 are DWC/new law.

2. **THIS DWC FORM-155 MUST BE COMPLETED IN ITS ENTIRETY**. Please print or type. Send a separate DWC FORM-155 request form for each claimant for which you are requesting a record check. The original DWC FORM-155 must be submitted to the Division.

3. **PAYMENT MUST ACCOMPANY THIS REQUEST FORM. THE REQUEST WILL BE RETURNED IF PAYMENT IS NOT ENCLOSED. FEES ARE SUBJECT TO CHANGE.**
   A. All record checks are $15.00 each.
   B. Certifications are $1.00 additional fee each. If a certified record check is requested, the record check response will have a letter of certification attached which is signed or stamped and sealed by the Custodian of Records, or his delegate, attesting to the authenticity of the attached document. See Section III.

4. The requestor **MUST** indicate the legal basis on which he or she is **eligible** to receive confidential claimant information. Check **only one** category in Section IV that reflects your eligibility to receive confidential information.
   A. An eligible insurance carrier must have handled a workers' compensation claim for the injured worker.
   B. An out of state insurance carrier or employer, or their legal representative, may be eligible to receive record check information. Documentation of a worker's compensation claim against that employer or the insurance carrier paying that claim must be provided to determine eligibility (also see number 5 below).
   C. Dates of employment or date of injury must be indicated if applicable.

5. A party eligible to receive record check information may authorize a legal representative to request and receive the information on their behalf. If legal representative is requestor, box must be checked for verification purposes. Refer to DWC Advisory 95-01 for requirements and additional information. To obtain a copy of this advisory visit the DWC website indicated above. To establish eligibility to receive confidential information, the legal representative of a party must provide documentation of representation, e.g. letter of representation from client, copy of the contract between the client and the representative or Original Answer.

6. The requestor **MUST** swear to the correctness of the entitlement information before a **notary public,** sign the completed form before the notary, and have the notary complete the sworn acknowledgment. The original signed and notarized form should be mailed or personally delivered to the address indicated at top of DWC FORM-155. Incorrectly attested forms will be returned to the requestor without action.

7. Cancellation of a request for a record check may be made by calling the Reprographics Section/Record Checks at (512) 804-4990 ext. 319. **No refunds will be made after the request has been processed.**

8. For additional assistance in completing this DWC FORM-155, or to make an inquiry regarding the status of your request, call the Reprographics Section/Record Checks at (512) 804-4990 ext. 319.

9. FAX requests and/or altered forms will **not** be accepted.

10. To obtain **copies of confidential claim files** complete and file Request For Copies Of Confidential Claimant Information DWC FORM-153. To obtain a **pre-employment check** on persons who have been given a tentative offer of employment, complete and file Prospective Employment Authorization and Certification DWC FORM-156.

11. Governmental Agencies/Political Subdivisions or regulatory bodies requesting confidential claimant information in a capacity other than as an employer, should not complete this form. Please contact DWC General Counsel at (512) 804-4275 for information concerning determination of eligibility to receive record check information.

IMPORTANT: BY EXECUTION OF DWC FORM-155, THE REQUESTOR REPRESENTS THAT HE OR SHE IS ENTITLED TO THE INFORMATION REQUESTED AND THAT HE OR SHE HAS FULL AUTHORITY TO ACT AS A REQUESTOR. IT IS A *CLASS A MISDEMEANOR* FOR UNAUTHORIZED PERSONS TO RECEIVE CONFIDENTIAL CLAIM FILE INFORMATION OR TO DISCLOSE SUCH INFORMATION TO UNAUTHORIZED PARTIES. TEXAS LABOR CODE §§ 402.064; 402.084; 402.086 & 402.091.