

PENNSYLVANIA WORKERS COMPENSATION RELEASE FORM

I authorize Compliance Background Screening Services to conduct a workers compensation case inquiry, in search of any and all information reported on my behalf to the Pennsylvania Department of Worker's Compensation, in compliance with the Federal Americans with Disabilities Act.

Name:	
AKA:	
Date of Birth:	
SSN:	

Signature: _____

Date: _____

Please fax records back to:

Compliance Background Screening Services

Attn: Phil Brattin

3909 Ambassador Caffery Pkwy

Lafayette, LA 70503

FAX: **800-403-9044**