



Instructions

- To obtain printed information from Version 3 (V3) or an imaged document filed after May 7, 2001, please complete this form and return it to the public information counter, or visit our Web site at ohioabc.com for information.

BWC use only

- Check authorization
Check for prior image request in notes
Enter note of images printed and for whom

Date of request

Form with fields: Injured worker name, Claim number, Requester name, Firm name, Representative ID number, Telephone number, Fax number

Please check the appropriate box(es) below:

Version 3 information

- General claim data
Claim notes
Payment plans
Wages information
Return-to-work dates
Incoming application tracking status
Claim assignment history
List of correspondence sent
Reprint correspondence (overnight)\* (specify below)

Imaged documents\*

- Medical reports
First Report of an Injury, Occupational Disease or Death (FROI)
C-84 (specify)
C-94-A/wages/check stubs
BWC exam(s) date(s)
IC order(s) date(s)
Appeal(s) date(s)
Entire claim (only one time, per party)
Other imaged documents (specify below)

Reply to requester

- No current authorization on file
No BWC orders/correspondence on V3
No wage/payment information on V3
Claim is medical only or self-insured
Requested image(s) not found
Other

\*Processing time is 24 to 48 hours depending on the request.



**Instructions**

You must complete and file this form each time an authorized person requests to inspect the file.

Claim number	Policy number
Injured worker	Employer

I, the undersigned, do hereby certify I have been duly authorized to inspect the file in this matter by

*(Full name of party authorizing inspection must be stated and whether injured worker, employer, or representative, of either.)*

At this time, I \_\_\_\_\_ employed by the party named above to represent them in this case.  
*(am or am not)*

If not employed as representative, state reasons for inspection: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Requested for inspection by**

Representative name <i>(please print, type or stamp)</i>	Representative ID number
Street address	City
Signature	Date

**Reply to requester**

Claim file not available

Claim file charged to the Industrial Commission of Ohio     Claim file destroyed

Claim file charged to the Office of the Attorney General of Ohio     Other \_\_\_\_\_

Claim file lost