

**AGENCY FOR WORKFORCE INNOVATION**  
**EMPLOYEE'S or EMPLOYER'S AUTHORIZATION AND REQUEST FOR WAGE RECORDS**  
**FOR THE ADMINISTRATION OF A WORKER'S COMPENSATION CLAIM**

Section 443.1715(2)(b)1, Florida Statutes, provides: The employer or the employer's workers' compensation carrier against whom a claim for benefits under Chapter 440, Florida Statutes has been made, or a representative of either, may request from the Agency for Workforce Innovation records of wages of the employee reported by an employer for the quarter that includes the date of the accident that is subject of such claim and for subsequent quarters. The request must be made with the authorization or consent of the employee or any employer who paid wages to the employee subsequent to the date of the accident.

**Section 1 – Requestor Information - NOTE: Please print the required information for all sections other than signatures.**

Any person who knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing false or misleading information is guilty of a felony. Section 440.105, F.S.

<p><i>NAME AND ADDRESS OF EMPLOYER/CARRIER (REQUESTOR)</i></p> <p><i>Employer/Carrier:</i></p> <p>_____</p> <p>_____</p>	<p><i>Name of Requestor:</i> _____</p> <p><i>Title:</i> _____</p>
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**Section 2 – Request for Wage Record Information**

**I REQUEST THE WAGE RECORDS ON THE FOLLOWING EMPLOYEE**

<i>Employee's Name (first, middle, last)</i>	<i>Social Security Number of Employee (Required for Record Retrieval)</i>
<i>Workers' Compensation Case File</i>	<i>Date of Accident</i>

**Section 3 – Employee Authorization (Completion of this section is not required if Section 4 is completed)**

The employee for whom wage records are requested must execute this section. The Agency for Workforce Innovation will provide wage data for the calendar quarter that contains the date of the accident as identified in Section 1, and for any subsequent calendar quarter for which data is available.  
**What this means to you the employee.** By signing this release you are authorizing the Agency for Workforce Innovation to provide a record of your wages for all employment, as defined in Chapter 443, F.S., following the date of your accident contained in Section 2.

<i>Employee's Signature:</i> _____	<i>Employee's Address:</i>
<i>Date Signed:</i> _____	_____
	<i>Employee's Telephone Number:</i> (     ) _____ - _____

**Section 4 – Employer Authorization (Completion of this section is not required if Section 3 is completed)**

**What this means to you the employer.** By signing this release you are authorizing the Agency for Workforce Innovation to provide the entity in Section 1, wage information on the individual identified in Section 2 that you have reported to the Department of Revenue on your quarterly UCT-6.

<i>Name of Employing Unit:</i> _____	<i>Name and phone number of the person the Agency may contact for verification, if necessary.</i>
<i>Employer's Signature:</i> _____	<i>Name:</i> _____
<i>Date Signed:</i> _____	<i>Telephone Number:</i> (     ) _____ - _____

**Section 5 – Certification and Agreement of Requestor**

**By signing and submitting this form, the requestor agrees to and/or acknowledges the following:**

1. The requestor certifies that he/she is the employer or the workers' compensation carrier, or the representative thereof, identified in Section 1 of this form.
2. The requestor shall use the information provided only for the purposes of determining whether the employee identified in Section 2 of this form is eligible for workers' compensation and for the purposes of any mediation, negotiation, arbitration, or litigation relating to the employee's claim for workers' compensation.
3. The requestor shall store the information in a location and manner that is inaccessible to unauthorized persons and made available only to authorized persons with a need for access to the information.
4. The requestor shall instruct all personnel having access to the information about the confidentiality requirements set forth in Ch. 443, F. S. and on this form.
5. The requestor acknowledges that anyone who unlawfully discloses the confidential wage information is guilty of a second degree misdemeanor. S. 443.1715, F. S.
6. The requestor acknowledges that AWI reserves the right to conduct an on-site inspection to assure the requirements of the law and agreement are being met.
7. The requestor agrees to pay costs associated with providing the data requested. Title 20 Part 603, Code of Federal Regulations.
8. The requestor understands that the information may contain inaccuracies due to errors made by employers in their quarterly wage reports and the Agency for Workforce Innovation shall not be responsible or liable for any errors contained in the information.

Signature of Requestor \_\_\_\_\_ Date: \_\_\_\_\_

**INSTRUCTIONS: For all requests Sections 1 and 2 of this form must be fully completed. In addition, either Section 3 or Section 4 must be completed. It is not necessary to obtain authorizations from both the employee and his or her subsequent employer. Mail completed request along with a self-addressed, postage paid envelope to: Agency for Workforce Innovation, Unemployment Compensation Records, PO Drawer 5750, Tallahassee, FL, 32314-5750**  
**Requests submitted without a self-addressed postage paid return envelope will not be honored.**