

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

1. REVISION DATE: <div style="text-align: center;">MM / DD / YYYY</div>		CERTIFICATE AUTHORIZING RELEASE OF UNEMPLOYMENT INFORMATION			2. WCB FILE NUMBER (if known):	
EMPLOYEE						
3. EMPLOYEE LAST NAME:		4. FIRST NAME:		5. MI.:	6. SOCIAL SECURITY NUMBER (last 4 digits): <div style="text-align: center;">XXX-XX-</div>	
7. STREET/P.O. BOX MAILING ADDRESS:		8. CITY:		9. STATE:	10. ZIP:	
11. HOME PHONE NUMBER:		12. DATE OF INJURY: <div style="text-align: center;">MM / DD / YYYY</div>		13. SPECIFIC INJURY OR ILLNESS:		
14. BODY PARTS (S) AFFECTED:						
EMPLOYER/INSURER						
15. INSURER FILE NUMBER:		16. EMPLOYER NAME:		17. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:		
18. INSURER NAME:		19. INSURER MAILING ADDRESS AND PHONE NUMBER:				

PART II (COMPLETED BY EMPLOYEE)

I, _____, understand that the information in my unemployment compensation file(s) is confidential under 26 M.R.S.A. §1082(7), of the Maine Revised Statutes.

However, I waive my right to confidentiality and authorize the Department of Labor to obtain and release benefit payment information, pertaining to the benefit year ending ____/____/____, or calendar period from _____ through _____ to the following:

Name: _____

Title: _____

Address: _____

I understand that I may also request a copy of this information be sent to me. A copy of this waiver/consent is acceptable. **The completed form should be faxed directly to Samantha Lee, Department of Labor, Bureau of Unemployment Compensation at 207-287-5908.**

Signature: _____ Date: _____

PART III (COMPLETED BY THE BUREAU OF UNEMPLOYMENT COMPENSATION)

Unemployment benefit payment information sent to the requestor on _____.

Signature: _____ Date: _____