



**STATE OF TENNESSEE**  
**BUREAU OF WORKERS' COMPENSATION**  
 220 FRENCH LANDING DRIVE  
 NASHVILLE, TENNESSEE 37243-1002  
 615-253-1842 or fax 615-532-8546  
[WC.Claims@tn.gov](mailto:WC.Claims@tn.gov)

**REQUEST FOR PRIOR WORK INJURY INFORMATION**

**This form is used to satisfy the requirement of T.C.A 50-3-702(b), which allows employers to verify the truthfulness of a job applicant concerning a possible prior work injury. NOTE: There is a \$10.00 fee for this service for each applicant named below. The Bureau will invoice the requester for the fee(s) after the records have been provided.**

Employer d/b/a Name \_\_\_\_\_

Requester Name \_\_\_\_\_

Requester Direct Phone # \_\_\_\_\_ Title \_\_\_\_\_

Street Address 1 \_\_\_\_\_

Street 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Please indicate the manner in which you want the invoice and search results returned to you.

Fax \_\_\_\_\_ or Email \_\_\_\_\_

\_\_\_\_\_  
 Signature of Requester

\_\_\_\_\_  
 Date

<b>Job Applicant(s) Name</b> (to be provided by the employer)	<b>Applicant(s) SSN</b> (to be provided by the employer)	<b># of Records Found</b> (to be provided by the Bureau)