

DIVISION OF INDUSTRIAL RELATIONS  
DIVISION OF WORKERS COMPENSATION

## Request for WCAB Case # Search

**Instructions:** In order to look at a WCAB case file, you must make the request in person at the DWC district office and provide both the name of the injured worker and the WCAB Case Number.

If you do not have **both** the name and the case number, you may obtain such information by completing this form and mailing it to:

**DWC Public Records Office  
Division of Workers' Compensation  
455 Golden Gate Avenue, Room 5151  
San Francisco, Ca 94102**

1. **Please complete the following (please print):**

Requestor Name: \_\_\_\_\_

DWC Authorization # (if any): \_\_\_\_\_

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Nature of requestor's business: \_\_\_\_\_

2. **If you are making this request on behalf of another, please provide the following data about the person  
Or entity you represent:**

Name: \_\_\_\_\_

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Nature of business: \_\_\_\_\_

**(Please complete reverse side of form)**

**DWC Form AD-2 (New 6/03)**

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3. Please explain why you want this information and the reasons why your client wants this information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Please provide as much identifying information as possible about this case:

Injured Workers Name: \_\_\_\_\_

Social Security # of Injured Worker: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

Body Part-Injured: \_\_\_\_\_

5. **Sign below and return this form as indicated in the instructions.**

NOTE: This Request is a Public Record. A record of this request will be retained by the DWC Public Records Office. By making this request you are declaring that you will not use the information you receive for illegal or unlawful purposes.

**I, the undersigned, declare under penalty of perjury under the laws of the State Of California, that I shall not use the information received pursuant to this request for illegal or unlawful purposes and that the foregoing is true and correct.**

\_\_\_\_\_  
Signature Date

\*\*\*\*\*

(To be completed by the Division of Workers' Compensation only)

\_\_\_ Your Request for WCAB case identification has been granted.  
WCAB case no: \_\_\_\_\_ File Location: \_\_\_\_\_

\_\_\_ We were unable to locate a WCAB case number for the injured worker.

\_\_\_ Your request for WCAB case identification has been denied because:

\_\_\_ Form not properly completed (see area circled).

\_\_\_ Form not signed.                      \_\_\_ Form illegible.

\_\_\_ Other: \_\_\_\_\_

Authorized Agent:

Knox Attorney Service, Inc./ Knox Services LLC.