MARSHALL ISLANDS WORKERS' COMPENSATION ADMINISTRATION

Head Office
P.O. Box 175, Majuro, Marshall Islands MH 96960
Phone: (692) 625-3101, Fax: (692) 625-4570
Email: rmiworkcomp@rmimissa.org
www.rmiworkcomp.org

Ebeye Branch
P.O. Box 5850, Ebeye, Kwajalein, MH96970
Phone: (692) 329-3788, Fax: 329-3902
Email: missaebeye@rmimissa.org

Form WCA-207
(Schedule 24)

AUTHORIZATION TO RELEASE PERSONAL AND MEDICAL INFORMATION

To: ___________________

Address: ____________________________

Dear Sir/Madam,

I, ___________________________, of legal age and resident of ____________, Village, ___________________, Republic of the Marshall Islands, with RMI Social Security No. 04-___________, do hereby authorize and request for the release of all information (as checked below), to the Marshall Islands Social Security Administration, the Administrator and Worker's Compensation Board of the Marshall Islands Workers' Compensation Program:

[ ] Medical Records [ ] Labor Office Records

[ ] Police Records [ ] Employment Records

[ ] Immigration Records [ ] Other ______________________
(please specify)

I do understand that the information requested above will be used strictly in connection with my claim for Workers' Compensation as a result of a work related injury/illness on ___________, 20___. I hereby expressly waive my privilege to confidentiality and right to privacy on the released documents as provided for by the laws of the Marshall Islands.

Dated this _____ day of _______________, 20___.

Notary Public

____
Name and signature of person signing

____
Name and signature of witness