

Mail or personally deliver this form to:  
TEXAS DEPARTMENT OF INSURANCE  
DIVISION OF WORKERS' COMPENSATION  
7551 Metro Center Drive, Suite 100, MS-92B  
Austin, TX 78744



**THIS FORM MUST BE FILLED OUT COMPLETELY AND  
MUST BE SIGNED AND DATED BEFORE A NOTARY.**

## PROSPECTIVE EMPLOYMENT AUTHORIZATION AND CERTIFICATION

Please carefully read the instructions on the reverse side before submitting this form. Incorrect/incomplete forms will be returned without action.

### SECTION I: TO BE COMPLETED BY JOB APPLICANT

1. Name of Job Applicant (Print or type)	3. Social Security Number
2. Complete Address of Job Applicant (Print or type)	4. Date Job Application Submitted

I understand that the Texas Workers' Compensation Act provides for the release of certain prior work related injury information to prospective Texas employers who carry workers' compensation insurance if the employer obtains my written authorization before making a request for that information. I also understand that if this employer is covered by the Americans With Disabilities Act, my prior work related injury claim information may be released only if the indicated employer has properly completed and certified the information on this form. Prospective employers filing valid requests will be provided with a report on prior work related injury claims only if an applicant has made two or more general injury claims in the preceding five years. I hereby authorize release of information permitted by law on my work related injuries to the prospective employer named below.

Job Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

SWORN AND SUBSCRIBED TO BEFORE ME BY THE SAID \_\_\_\_\_ (Print Job Applicant's Name)

ON THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, YEAR \_\_\_\_\_.

\_\_\_\_\_  
Signature of Notary Public

\_\_\_\_\_  
Print Name of Notary Public  
(Seal or Stamp)

My Commission expires: \_\_\_\_\_

### SECTION II: TO BE COMPLETED BY PROSPECTIVE TEXAS EMPLOYER

1. Name of Employer (Print or type)	3. Employer's Federal Tax I.D. #	4. Date Job Application Received
2. Address and Phone Number of Employer (Print or type)	Phone Number ( )	5. Prepaid Account Number

I am a prospective Texas employer who has workers' compensation insurance. I am entitled to receive prior injury information concerning this job applicant under the Texas Workers' Compensation Act, Texas Labor Code, Section 402.087. I am not prohibited from receiving this information under the Americans With Disabilities Act of 1990, 42 U.S.C. §12101 *et. seq.* because:

(Employer Must Check One):

- I am a Texas employer who is not covered by the Americans With Disabilities Act of 1990. (The Americans With Disabilities Act of 1990 defines "employer" as: "a person engaged in an industry affecting commerce who has 15 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding year and any agent of such person").
- I am a Texas employer who is covered by the Americans With Disabilities Act of 1990, who is requesting this information prior to hiring the above-named job applicant, but after having made a conditional offer of employment to the above-named applicant. I am requesting this information regarding all post-offer prospective job applicants in this job category, regardless of disability. Information concerning the Americans With Disabilities Act may be obtained by calling 1 (800) 949-4232; TDD 1 (713) 520-5136 or the Texas Commission on Human Rights, (512) 437-3450.

**A \$2.00 fee is required of the prospective employer per request. Your remittance must be attached. The DWC FORM-156 will be returned without action if payment is not enclosed. Fees are subject to change. Make checks payable to DWC.**

I certify that I am an authorized representative of this employer and the statements in Section II of this document are true, complete and correct to the best of my knowledge and belief.

Employer/Representative's Signature \_\_\_\_\_ Date \_\_\_\_\_

SWORN AND SUBSCRIBED TO BEFORE ME BY THE SAID \_\_\_\_\_ (Print Employer/Rep. Name)

ON THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, YEAR \_\_\_\_\_.

\_\_\_\_\_  
Signature of Notary Public

\_\_\_\_\_  
Print Name of Notary Public  
(Seal or Stamp)

My Commission Expires: \_\_\_\_\_



**DWC FORM - 156**  
**PROSPECTIVE EMPLOYMENT AUTHORIZATION AND CERTIFICATION INSTRUCTION SHEET**  
[www.tdi.state.tx.us](http://www.tdi.state.tx.us)

GENERAL:

1. **PAYMENT MUST BE SUBMITTED WITH EACH REQUEST.** Each DWC FORM-156 processed will require a \$2.00 fee, which includes postage. The form will be returned without action if payment is not enclosed. Fees are subject to change. **Make checks payable to DWC.**
2. Use DWC FORM-156, PROSPECTIVE EMPLOYMENT AUTHORIZATION AND CERTIFICATION form, to obtain confidential claim file information on persons who have submitted an application for employment. The Division will provide the dates of injury and descriptions of two or more general injury claims filed by the applicant within the past five years. The use of this service is not mandatory. Refer to Advisory 99-01 for additional information. To obtain a copy of this advisory visit the DWC website indicated above.
3. DWC FORM-156 **MUST BE COMPLETED IN ITS ENTIRETY.** Please print or type. The **original** signed and notarized form must be mailed or personally delivered to the address indicated at top of DWC FORM-156, not more than 14 days after the date on which the application for employment is submitted.
4. For additional assistance in completing DWC FORM-156, call the Reprographics Section/Pre Employment at (512) 804-4990-ext. 391.
5. DWC FORM-156 may not be FAXED and will be returned without action. Confidential information will not be released by telephone.
6. In order to be eligible to receive confidential information, the Texas employer must carry Workers' Compensation Insurance coverage. Coverage will be verified before information will be released.

SECTION I - JOB APPLICANT INFORMATION

1. The applicant must provide his/her full name, address and social security number. The date the job application was submitted must be indicated in Section I, Box 4.
2. The applicant must sign the request form before a notary and have the notary complete the acknowledgement portion.

SECTION II - EMPLOYER INFORMATION

1. The Texas employer must provide the company name, address, phone number and Federal Tax I.D. number.
2. The Texas employer may authorize an employee of the company to request and receive the confidential information on the employer's behalf. The authorized employee must sign the request form before a notary and have the notary complete the acknowledgment portion. Incomplete or incorrectly attested forms will be returned to the employer without processing.
3. Information regarding the Americans with Disabilities Act must be completed by checking ONE of the boxes.

**IMPORTANT:**

**BY EXECUTION OF DWC FORM-156, THE TEXAS EMPLOYER REPRESENTS THAT HE OR SHE IS ENTITLED TO THE INFORMATION REQUESTED AND THAT HE OR SHE HAS FULL AUTHORITY TO ACT AS A REQUESTOR. IT IS A CLASS A MISDEMEANOR FOR UNAUTHORIZED PERSONS TO RECEIVE CONFIDENTIAL INFORMATION OR TO DISCLOSE SUCH INFORMATION TO UNAUTHORIZED PARTIES. TEXAS LABOR CODE SECTIONS 402.064; 402.084; 402.087 & 402.091.**

