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

1. REVISION DATE: ____/____/____ MM DD YYYY	**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): XXX-XX-	
7. STREET/P.O. BOX MAILING ADDRESS:	8. CITY:	9. STATE:	10. ZIP:	11. HOME PHONE NUMBER:
12. DATE OF INJURY: ____/____/____ MM DD YYYY	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 Lisa Bosse, Department of Labor, Bureau of Unemployment Compensation Imaging Division at 207-287-2305.**

Signature:_____ Date:_____

PART III (COMPLETED BY THE BUREAU OF UNEMPLOYMENT COMPENSATION)

Unemployment benefit payment information sent to the requestor on _____.

Signature:_____ Date:_____

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.
WCB-7 (effective 9/1/2020)