



INDIANA  
**WORKFORCE**  
DEVELOPMENT  
AND ITS **WorkOne** CENTERS

**RELEASE OF INFORMATION**

\*NAME OF APPLICAN (PRINT) \_\_\_\_\_

\*SOCIAL SECURITY: \_\_\_\_\_

\*CURRENT DATE: \_\_\_\_\_

I authorize the Indiana Department of Workforce Development to release all wage and unemployment benefit information to the agency listed below.

\_\_\_\_\_  
**\*SIGNATURE OF APPLICANT**

Check this box if Power of Attorney is attached

By signing below you agree that you understand that data we release to you is protected under state law (IC 22-4-19-6) and federal regulations (20 CFR § 603.5) as confidential information. You also confirm that you have verified the applicant's identity by viewing some type of photo identification.

**\*NOTE: RELEASE MUST BE SUBMITTED WITHIN 90 DAYS OF APPLICANT SIGNING RELEASE FORM.**

\*Signature of Requestor: \_\_\_\_\_

Requesting Agency: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**\*REQUIRED FIELDS:** For questions email [EmployVerification@dwd.IN.gov](mailto:EmployVerification@dwd.IN.gov)