



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

**RELEASE OF INFORMATION**

NAME OF APPLICANT: \_\_\_\_\_

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

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: \_\_\_\_\_

Phone Number: \_\_\_\_\_

For questions email [EmployVerification@dwd.IN.gov](mailto:EmployVerification@dwd.IN.gov)