U.S. Department of Labor
Office of Workers' Compensation Programs
P.O. Box 8300
London, KY 40742-8300

RE: Claimant: _____

Date of Birth: _____

Social Security No.: _____

Date of Injury: _____

OWCP File No.: ___-_____

I hereby authorize Attorney Jacqueline Shanahan to inspect and copy any and all of my Federal Employee's Compensation Act Claim Files, including, but not limited to ____-_____.

I am willing that a photocopy and/or a fax copy and/or an e-mail copy of this authorization be accepted with the same authority as the original. I request that you provide the copy of the file(s) without fee.

_____
Signature

_____
Printed Name

HOME ADDRESS: _____

_____

TELEPHONE NUMBERS: HOME: _____

CELL: _____

NAME OF EMPLOYER:_____

E-MAIL ADDRESS:_____
(please print legibly)