



# WAIVER AND AUTHORIZATION

Iowa Workforce Development is hereby authorized to provide to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Any personal and/or business information concerning unemployment insurance claims, accounts, or any other pertinent information regarding my interactions, past or present, with Iowa Workforce Development.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Full Name of Claimant or Employer

\_\_\_\_\_  
Full Social Security Number or EIN Number

\_\_\_\_\_  
Claimant's Date of Birth

\_\_\_\_\_  
Telephone Number

**Additional Verification for Claimant requesting their own records.** You **must** provide **one** of the following items listed below:

Question	Answer
Last Date Worked	
Current Employer Name	
Amount of Last Benefit Payment	
Number of Dependents	
State Date of Last Employer	

1000 E Grand Avenue • Des Moines, IA 50319 • iowaworkforcedevelopment.gov  
Equal Opportunity Employer/Program  
Auxiliary aids and services available upon request to individuals with disabilities.  
For deaf and hard of hearing, use Relay 711.

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