

AUTHORIZATION TO OBTAIN EMPLOYMENT INFORMATION

EMPLOYER: _____

The undersigned hereby authorizes the above-named employer, and any other firm or employer by whom I am or by whom I have been employed, to give to the law office of BRUCE D. SCHUPP all information in their possession regarding my position, job title, nature of my work, hours and time lost from work before and after the accident or occurrence of _____.

I further authorize those firms or employers to release all information related to amounts paid or due under any sick leave plan, wage continuation plan or group hospital or accident benefit plan, including the identity and address of the insurance carrier, as well as tips, commissions and/or bonuses.

I agree that a photocopy of this authorization shall be as valid as the original, and direct the recipient to disclose the above-described information about me as though it were the original.

I agree that this authorization shall remain valid for one year from the date signed.

Dated this _____ day of _____, 20__.

x _____