Claim Number _____

District Director
US Department of Labor
Office of Workers' Compensation
PO Box 8300
London, KY 40724

Dear District Director,

Please send me a complete copy of my OWCP file #_____.

Thank you for your prompt attention to this request.

Sincerely,

_____ _____

Signature Date

(Print)

Name _____

Address _____

_____

Phone _____