| Form SF-8<br>Rev. 1-1-2001 | ARKANSAS WORKERS' COMPENSATION COMMISSION<br><br>SPECIAL FUNDS DIVISION | SF-8 |
|---|---|---|
| Authority:<br>Ark. Code Ann.<br>§11-9-527(d)(2) | 324 Spring Street, P. O. Box 950, Little Rock, AR 72203-0950<br>501-682-5187 / 1-866-880-8444 (Toll-free) | |

## AUTHORIZATION FOR RELEASE OF STUDENT INFORMATION

Attention: Registrar's office

I, (print full name) _____ , a student at your institution, do hereby authorize you to furnish copies of any and all records pertaining to my enrollment at (institution name) _____

at _____
(City) (State) (Telephone)

to the Arkansas Workers' Compensation Commission, Death and Permanent Total Disability Trust Fund, at the above address, and also to provide such information by telephone to employees of the Trust Fund upon their request. A photostatic copy of this authorization shall be as valid and effective as the original at any time hereafter, unless revoked by me in writing.

Dated the _____ day of _____, 2_____.

Signed: _____

Social Security Number: _____

Student ID No.: _____

Date of birth: _____

Address: _____

City, State, ZIP: _____