

Case Information

Applicant: _____ DOB: _____ SS No. _____

Address: _____

Home phone: _____ Work phone: _____

Case

Case number: _____ DOI: _____ Age at DOI: _____

How injury occurred: _____

Body parts: _____

Occupation at time of injury: _____ Group number: _____

Attorney: _____ Phone: _____

Firm: _____ FAX: _____

Address: _____

Prior Attorney: _____ Phone: _____ Date of subst: _____

Temporary Disability

Last Day Worked (LDW): _____ Returned to Work Date (RTW): _____

TTD start: _____ Dr. _____ Date of report: _____ Page: _____

TTD end: _____ Dr. _____ Date of report: _____ Page: _____

Correct TTD weekly rate: \$ _____ Number of weeks of TTD: _____

Total amount of TTD that should have been paid: \$ _____

Total amount of TTD that was paid: \$ _____

Permanent Disability Advances

P&S date: _____ Dr. _____ Date of report: _____ Page: _____

PDA legal start date: _____ PDA actual start date: _____ Weekly Rate: \$ _____

PDA end date: _____

Total PDA received: \$ _____ As of (date): _____

Vocational Rehabilitation

Q/W date: _____ Dr. _____ Date of report: _____ Page: _____

VR demand date: _____ VRMA start date: _____ end date: _____ Rate: _____

Interrupt date: _____ Restart date: _____ Wants further VR: _____

Period of VRMA not paid From: _____ To: _____

Total amount of retroactive VRMA owed: _____

Other considerations: _____

Third party case: _____

132a: _____

S&W: _____

Credit: _____

Wrongful termination: _____

Defendant Information

1. Employer: _____

Period worked: From: _____ To: _____ Terminated: _____

Hourly rate: \$ _____ Hours per week: _____ Weekly gross earnings from all sources: _____

Insurance company: _____ Phone: _____

Address: _____

Claim number: _____ Policy number: _____ Coverage admitted: _____

Coverage within LC §5500.5 period From: _____ To: _____ Percentage: _____

Claim denied: _____ Date of Denial: _____

Claim admitted: _____ Date of Acceptance: _____ Treatment provided: _____

Claims Admin: _____ Phone: _____ E-mail: _____

Company: _____ FAX: _____

Address: _____

Attorney: _____ Phone: _____ E-mail: _____

Firm: _____ FAX: _____

Address: _____

2. Employer: _____

Period worked: From: _____ To: _____ Terminated: _____

Hourly rate: \$ _____ Hours per week: _____ Weekly gross earnings from all sources: _____

Insurance company: _____ Phone: _____

Address: _____

Claim number: _____ Policy number: _____ Coverage admitted: _____

Coverage within LC §5500.5 period: From: _____ To: _____ Percentage: _____

Claim denied: _____ Date of Denial: _____

Claim admitted: _____ Date of Acceptance: _____ Treatment provided: _____

Claims Admin: _____ Phone: _____ E-mail: _____

Company: _____ FAX: _____

Address: _____

Attorney: _____ Phone: _____ E-mail: _____

Firm: _____ FAX: _____

Address: _____

Medical Reports Summary

(use multiple pages)

Physician: _____ PTP/QME/AME: _____ For: _____

Specialty: _____ Date of exam(s): _____ Date of report(s): _____

P&S Date: _____ Report Date: _____ Page: _____

TTD From: _____ Thru: _____ Date of Report: _____ Page: _____

Permanent disability: _____

Rating: _____

Apportionment: _____

Future medical treatment: _____

Q/W: _____

Remarks: _____

Physician: _____ PTP/QME/AME: _____ For: _____

Specialty: _____ Date of exam(s): _____ Date of report(s): _____

P&S Date: _____ Report Date: _____ Page: _____

TTD From: _____ Thru: _____ Date of Report: _____ Page: _____

Permanent disability: _____

Rating: _____

Apportionment: _____

Future medical treatment: _____

Q/W: _____

Remarks: _____