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LITIGATION REFERRAL SHEET*

Date: ______________________________

From: ______________________________ ______________________________
Adjuster Carrier or Administrator

Applicant: ______________________________ Employer: ______________________________

DOB: ______________________________ SSN: ______________________________

WCAB #: ______________________________ Claim #: ______________________________

Date of Injury: ______________________________

Entire Coverage or P.S.I. Period: ______________________ To ______________________

Entire Employment Period: ______________________ To ______________________

TD Paid $____________________ From ____________________ To ____________________

Average Weekly Wages: ____________ TD Rate ____________ PD Rate ____________

Why TD Terminated: ____

PD Paid $____________________ From ____________________ To ____________________

Date of Hearing

Total PD Advance

Suggested Issues: (please check)

_____ Employment
_____ Occupation
_____ Insurance Coverage
_____ Permanent Disability
_____ Temporary Disability
_____ Further Medical Care
_____ Self-Procured Medical Care
_____ Earnings
_____ Subrogation
_____ Statute of Limitations
_____ Apportionment
_____ Jurisdiction
_____ Vocational Rehabilitation
_____ Owner Operator
_____ Occupational Accident Policy
_____

Medical Preparation:

Original Medical Reports Are:
______ Attached ______ Filed _______
Copies served on Applicant:
______ Yes ______ No

Has further medical exam been scheduled?
______ Yes ______ No

If yes:
With whom ______________________________
When ______________________________

Applicant's Medical/Legal Liens Paid:
____
____
____

*Note: One sheet for each injury.