Workers Comp Record Request

Attorney Name

First Name

Last Name

Contact E-mail

Applicant

First Name

Last Name

Also Known As

ADJ

SSN

VS.

Opposing Party

Court Location City

Date of Birth

Month Day Year

Date of Injury

Month Day Year

Through

Month Day Year

Date Ordered

Month Day Year

- [ ] Dr. Appointment
- [ ] Trial Date

Date Required

Month Day Year

- [ ] Authorization Enclosed
- [ ] Prepare and Serve SDT

Carrier / Insurance

Phone Number

Claim/File #

Obtain Case File

◯ Yes
◯ No

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Adjustor

First Name

Last Name

Direct Phone

Phone Number

Fax

Fax Number

E-mail

Employer

Phone Number

Obtain Personnel File

◯ Yes
◯ No

Attention

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Facilities to Obtain Records From

Facility 1

Name

Phone Number

Phone Number

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Date of Service

Month Day Year

Facility 2

Name

Phone Number

Phone Number

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Date of Service

Month Day Year

Facility 3

Name

Phone Number

Phone Number

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Date of Service

Month Day Year

Facility 4

Name

Phone Number

Phone Number

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Date of Service

Month Day Year

Facility 5

Name

Phone Number

Phone Number

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Date of Service

Month Day Year

Facility 6

Name

Phone Number

Phone Number

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Date of Service

Month Day Year

Facility 7

Name

Phone Number

Phone Number

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Date of Service

Month Day Year

Doctor

Full Name

First Name

Last Name

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Phone Number

Area Code

Phone Number

Copying and Mailing Instructions

Copying Instructions

- [ ] No Ommisions
- [ ] Omit Nurses Notes
- [ ] Omit Lab Notes
- [ ] Omit Other (explain in Special Instuctions below)

Total Sets Required

Use the Special Instructions section below to specify additional addresses and number of sets to send to each.

Mailed to

First Name

Last Name

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Special Instructions

Submit