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Claim No.		**Date of Injury:**		**WCAB Case No:**	
Claimant:			**Claimant Address:**		
D.O.B.:			**SSN:**		
Employer:			**Employer Address:**		
Applicant's Attorney & Phone:					

Suggested Issues:

☐ **Injury**	☐ **Earning**	☐ **Past Medical**	☐ **Dependency**
☐ **Employment**	☐ **TD____**	☐ **Future Medical**	☐ **Rehabilitation**
☐ **Occupation**	☐ **PD____**	☐ **Statute of Limitations**	☐ **Lien Resolution**
☐ **Coverage**	☐ **Apportionment**	☐ **Jurisdiction**	☐ **Other:**

Medical Evaluation: ☐ **Please Set** ☐ **Already Scheduled w/Dr.** **on**

❑ **MSC** ❑ **PTC** ❑ **LIEN CONF.** ❑ **TRIAL** ❑ **DEPO** ❑ **OTHER:**

Date:		**Time:**		**Location:**		**Judge:**	

Remarks/Suggestions:

Carrier Name:				***Administering for:***	
Address:				**Suite #:**	
City:		**State:**		**Zip Code:**	
Adjuster Name:				**Phone No. & Ext.**	

If you would like to refer/send your file electronically, please submit the file documents along with the file referral form to e-docs@bradfordbarthel.com