



THE LAW OFFICES OF
BRADFORD & BARTHEL, LLP

AUDIT CONSULTATION REFERRAL

with Sherri Dozier

Request Date: _____

Name of Referring Contact: _____ Contact Phone#: _____

Applicant Name: _____ Applicant Age (DOB): _____

Name of Carrier/TPA: _____

Claim Number: _____ Date(s) of Injury: _____

Employer's Name: _____

Employer Business Description: _____

Applicant's Position (Title & Description): _____

Employer's Address: _____

Employer's Phone #: _____ Employer's FAX #: _____

Applicant's Legal Representation: _____

Required Documentation (please check all included):

Medical Records

Workers' Compensation Claim

Insurance Policy

Other Documentation

Brief Explanation of ALL Issues & Questions to Be Addressed:
