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Claim No.		**Date of Injury:**		**WCAB Case No:**	
Claimant:			**Claimant Address:**		
D.O.B.:			**SSN:**		
Employer:			**Employer E-mail / Phone Number:**		
Name of Employer Contact:			**Employer Address:**		
Date of Subpoena:			**Name of Subpoena Company:**		
Date Subpoena must be complied by:					
Applicant's Date of Hire:					
Applicant's Date of Termination:			**Denied or Admitted Injury:**		
Returned documents Attn to:			**Returned documents via:**	❑**E-mail** ❑**Regular** ❑**Certified** ❑**Personal and Confidential**	
Carrier Name:			***Administering for:***		
Address:			**Suite #:**		
City:		**State:**	**Zip Code:**		
Adjuster Name:			**Phone No. & Ext.**		
Adjuster Email					

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