LEGAL REFERRAL

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Rev: ~~8~~/8/2017

Claim No:	**Date of Injury:**	**WCAB Case No:**
Claimant:		***Employer:***
D.O.B.:	**SSN:**	**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. _____