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To (Attorney Preference):	**From:**		
____________________	____________________ **Adjuster Name**	____________________ **Adjuster Email**	____________________ **Adjuster Direct Phone Number**

Hearing or Deposition Set? ☐ Yes ☐ No	Hearing/Deposition Type	Hearing/Deposition Date and Time	Hearing/Deposition Location
AME or PQME Set? ☐ Yes ☐ No	AME/PQME Date and Doctor	WCAB Case Number	WCAB Location
Attorney Services Requested:	☐ Full Handling ☐ Attempt AME or PQME	☐ Appearance Only at Deposition or Conference ☐ Walk Through of Signed Settlement Docs	☐ Applicant's Deposition ☐ File Application ☐ Doctor's Deposition ☐ File DOR
Claim Number	Policy Period	Policy Number	Date of Injury
Claimant	Claimant's Address		90th Day
Employer	Employer's Address		☐ Accepted ☐ Delayed ☐ Denied Date:
If Adjusting for Carrier, Name and Address of Insurance Company			Date of Birth / Age on DOI Social Security Number
Average Weekly Wage	Occupation	Date of Hire	Last Date Worked
Temporary Disability Paid	Rate	Period Covered	Total TD Paid
Permanent Disability Paid	Rate	Period Covered	PD Advances Paid
Claimant's Attorney	Attorney's Address		Medicals Paid

Suggested Issues:
☐ Apportionment ☐ Contribution ☐ Coverage ☐ Dependency
☐ Earnings ☐ Employment ☐ IMR ☐ Injury
☐ Jurisdiction ☐ LC132a ☐ Liens ☐ Medical Care
☐ MPN ☐ MSA ☐ Occupation ☐ Penalties
☐ Permanent Disability ☐ Public Safety Officer ☐ S&W ☐ Statute of Limitations
☐ Subrogation ☐ Temporary Disability ☐ Other (Explain)

Suggested Documents Provided: ☐ Job Description ☐ Wage Statement ☐ Benefits Print Out ☐ Claims Activity Log ☐ Subpoenaed Records ☐ Meds

Any Important Deadlines?

Remarks and Instructions

Submitted by (signature)	Date