

WORKERS COMPENSATION REQUEST FOR INVESTIGATION

AOE/COE INVESTIGATION		SUBROSA INVESTIGATION	
Witnesses <input type="checkbox"/>	Employer <input type="checkbox"/>	Number of Days _____	Activity Check <input type="checkbox"/>
Employee <input type="checkbox"/>	S&W/132A <input type="checkbox"/>	Restrictions _____	
Medical Release <input type="checkbox"/>		Other _____	
OTHER INVESTIGATION			
Witness Names _____		Criminal Search <input type="checkbox"/>	Police Report <input type="checkbox"/>
Individuals to be Interviewed _____		Civil Search <input type="checkbox"/>	Fraud Referral <input type="checkbox"/>
Policies & Procedures Manual Needed? YES NO		WCAB Search <input type="checkbox"/>	Other <input type="checkbox"/>

CLAIMANT INFORMATION			
Claimant Name _____	Height _____	Race _____	Employer _____ Address _____ Contact _____ Phone _____ E-mail _____
Address _____	Weight _____	Gender _____	
Phone _____	Hair Type _____	DOB _____	
Married YES NO	Hair Color _____	SS # _____	
Spouse Name _____	Other (glasses, tattoos, facial hair, etc.) _____	Drivers Lic # _____	
Job ID Photo Available? YES NO	Known Vehicles _____		
Physical Limitations _____			
Use of Durable Medical Equipment (crutches, neck brace, etc.) _____			
Job Title _____	Date of Hire _____	Body Part _____	
Date of Injury _____	Description of Injury _____		
Job Description _____			

ADJUSTER / CLIENT INFORMATION	
Claim # _____	Physician Name _____
Examiner _____	Practice Name _____
Company _____	Address _____
Address _____	Phone _____
Phone# _____	Scheduled Appts. _____
Fax # _____	
E-mail _____	
Other Information / Instructions: _____	

REPORT ADDRESSED TO / DEFENSE ATTORNEY	
Name _____	Phone _____
Firm _____	Fax _____
Address _____	E-mail _____
	# of copies _____
Report Due Date _____	Claim on Delay YES NO
Decision Date _____	Authority or Budget _____