TESTAN LAW

LEGAL TRANSMITTAL
WORKERS COMPENSATION/SUBROGATION

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EMPLOYEE

EMPLOYEE ADDRESS CITY STATE ZIP

EMPLOYER

EMPLOYER ADDRESS CITY STATE ZIP

DATE(S) OF INJURY DATE OF HIRE

DATE OF BIRTH SOCIAL SECURITY NO.

CLAIM NUMBERS(S)

WCAB NUMBERS(S) OCCUPATION

CARRIER POLICY PERIOD

SUGGESTED ISSUES

(1) Injury AOE/COE
(2) Parts of Body Injured
(3) Period of Temporary Disability
(4) Earnings
(5) Permanent Disability
(6) Self-Procured Medical
(7) Future Medical
(8) Employment - Independent Contractor
(9) Coverage
(10) Occupation
(11) Statute of Limitations
(12) Vocational Rehabilitation
(13) Death and Dependency
(14) LC 132a
(15) Serious & Wilful Against Employer
(16) Serious & Wilful Against Employee
(17) Subrogation
(18) LC 5814 Penalty
(19) 90-Day Deadline Approaching

URGENCY OR SPECIAL HANDLING INSTRUCTIONS

Attorney Preference:_____

DOR Filed? ❑Yes ❑No: ___/___/___

Appearance Type_____Date:___/___/___

Deposition Scheduled or needed?:_____

Medical Exam Scheduled or needed?_____

With whom & When?_____

90-day deadline approaching? ❑Yes ❑No:: ___/___/___

Original medical reports are: ❑attached ❑filed ___

Copies served on applicant: ❑Yes ❑No::

BENEFITS PAID (Omit Summary if attached)

Earnings: _____per _____

Avergage Weekly Wage based on wage statement:? ❑Yes ❑No:
(If yes, please attach to this document)

Medical Treatment _____

Permanent Disability _____

VRTD _____

Temporary Disability Rate _____

Dates TD Paid _____

POST 1-1990 CASES ONLY

Claim form received: ❑No ❑Yes: ___/___/___

90th day to accept or deny is ___/___/___

Denied within 90 days? ❑Yes ❑No Date: ___/___/___

If disabled for 90 days - QRR assigned? ❑Yes ❑No

Application filed? ❑No ❑Yes: ___/___/___

EXAMINER'S REMARKS:

EXAMINER: _____ Company: _____

Date: _____ Telephone: _____