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 NUMBER(S)

WCAB NUMBER(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. Employent - Independent Contractor
9. Coverage
10. Occupation
11. Statute of Limitations
12. Vocational Rehabilitation
13. Death and Dependency
14. LC 132a
15. Serious & Willful Against Employer
16. Serious & Willful Against Employee
17. Subrogation
18. LC 5814 Penality
19. 90-Day Deadline Approaching

URGENCY OR SPECIAL HANDLING INSTRUCTIONS

Attorney preference: _____

DOR filed? ☐ Yes ☐ No: ____/____/____

Appearance type: _____

Deposition scheduled or needed? _____

Medical exam scheduled or needed? _____

With whom and 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 _____

Average 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: