WORKERS' COMPENSATION LITIGATION REFERRAL

WALL McCORMICK BAROLDI & DUGAN

A Professional Corporation
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Santa Ana, CA 92705
Phone: 714/547-7266
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DATE OF HEARING

DATE OF INJURY _____

APPLICANT		**EMPLOYER**	
WCAB NO.		**CLAIM NO.**	
ENTIRE COVERAGE OR P.S.I. PERIOD	TO	ENTIRE EMPLOYMENT PERIOD	TO
AVERAGE WEEKLY WAGES	$	WHY TD TERMINATED	
TD PAID	$	FROM	TO	TD RATE
TD PAID	$	FROM	TO	TD RATE

SUGGESTED ISSUES: (PLEASE CHECK)

☐ EMPLOYMENT	☐ FURTHER MEDICAL CARE	☐ JURISDICTION
☐ OCCUPATION	☐ SELF-PROCURED MEDICAL CARE	☐ SUBROGATION
☐ INJURY	☐ EARNINGS	☐
☐ INSURANCE COVERAGE	☐ DEPENDENCY	☐
☐ PERMANENT DISABILITY	☐STATUTE OF LIMITATIONS	☐
☐ TEMPORARY DISABILITY	☐ APPORTIONMENT	☐

MEDICAL PREPARATION:

ORIGINAL MEDICAL REPORTS ARE: ☐ ATTACHED ☐ FILED COPIES SERVED ON APPLICANT: ☐ YES ☐ NO

HAS FURTHER MEDICAL EXAM BEEN SCHEDULED: ☐ YES ☐ NO

IF YES: WITH WHOM: _____ WHEN: _____

MEDICAL/LEGAL LIENS PAID:

Remarks:

_____

CARRIER

FROM _____ OF _____ **PHONE #** _____

ADJUSTER **ADMINISTRATOR**