REQUEST FOR SERVICE

COMPANY NAME:		**EMPLOYEE NAME:**	
CLAIM #	ASSIGNED BY	ADDRESS	
ADDRESS		CITY/STATE/ZIP	
CITY/STATE/ZIP		PHONE	ALTERNATE PHONE
PHONE	FAX	DATE OF INJURY	DATE OF BIRTH
WATTS	TYPE OF COVERAGE	OCCUPATION	SOCIAL SECURITY NUMBER

EMPLOYER NAME:		CONTACT PERSON
ADDRESS		PHONE
CITY/STATE/ZIP		FAX
DATE OF HIRE	AVERAGE WEEKLY WAGE	COMP RATE

ATTORNEY FOR EMPLOYEE:		**ATTORNEY FOR EMPLOYER:**	
ADDRESS		ADDRESS	
CITY/STATE/ZIP		CITY/STATE/ZIP	
PHONE	FAX	PHONE	FAX

PHYSICIAN	PHONE	FAX
ADDRESS	CITY/STATE/ZIP	

TYPE OF INJURY: ____

ATTENDANT CARE ASSESSMENT	☐	SOCIAL SECURITY DISABILITY	☐	RE-EMPLOYMENT ASSESSMENT	☐
CATASTROPHIC MANAGEMENT	☐	JOB DEVELOPMENT/PLACEMENT	☐	TRANSFERABLE SKILLS ANALYSIS	☐
MEDICAL MANAGEMENT	☐	LABOR MARKET SURVEY	☐	VOCATIONAL EVALUATION	☐
THREE POINT CONTACT	☐	PSYCHOLOGICAL EVALUATION	☐	LIFE CARE PLAN & PAYMENT HISTORY	☐

INSTRUCTIONS & INFORMATION: ____

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MEDICAL RECORDS: ENCL'D ☐ **WILL SEND** ☐ **JOB DESCRIPTION: ENCL'D** ☐ **WILL SEND** ☐

Date Rec'd: _________ **Date Asgn'd:** ____________ **Rec'd By:** _______________ **Counselor/Nurse:** ___________________