

FILE TRANSMITTAL/REFERRAL
CONFIDENTIAL -ATTORNEY CLIENT PRIVILEGE

WITZIG, HANNAH, SANDERS & REAGAN, LLP
ATTORNEYS AT LAW

DATE FILE REFERRED: _____ FILE TO: _____

PLEASE SEND MATERIALS TO SANTA CRUZ OFFICE:

600 OCEAN STREET
SANTA CRUZ, CA 95060

210 NORTH FOURTH STREET, SUITE 201
SAN JOSE, CA 95112

PHONE 831-425-2835
OR 408-280-5600
FACSIMILE 831-425-2839

CLAIMS EXAMINER/COMPANY INFORMATION

Claims Examiner: _____ Direct Phone: _____
Company: _____ Fax: _____
Address: _____ Claim No(s): _____

Claims Examiner Remarks/Special Instructions: _____

CLAIMANT/APPLICANT ADDRESS

Applicant Attorney: _____

EMPLOYER ADDRESS

Employer Contact: _____

Copy Contact with correspondence? Yes __ No __

APPLICANT/CASE INFORMATION

Date of Birth: _____ Date of Hire: _____ Still Employed? _____
Job Title : _____ Average weekly wage: _____
Date of Injury: _____ Date of Claim Form: _____ Decision Date _____
Has case been activated? _____ Hearing date? _____ Time: _____
Hearing Location: _____
Other appearance scheduled? _____ Type: _____ Date: _____ Time: _____
Appearance Location: _____

ISSUES		BENEFIT INFORMATION	
<input type="checkbox"/> Injury	<input type="checkbox"/> Past Medical	Total TD Paid: _____	
<input type="checkbox"/> Employment	<input type="checkbox"/> Future Medical	Weekly Rate: _____	
<input type="checkbox"/> Occupation	<input type="checkbox"/> Statute of Limitations	Dates Paid: _____	
<input type="checkbox"/> Coverage	<input type="checkbox"/> Lien	Total PD Paid: _____	
<input type="checkbox"/> Earnings	<input type="checkbox"/> Dependency	Weekly Rate: _____	
<input type="checkbox"/> Temporary Disability	<input type="checkbox"/> Costs	Dates Paid: _____	
<input type="checkbox"/> Permanent Disability	<input type="checkbox"/> Penalty	Total Medical Paid: _____	
<input type="checkbox"/> Vocation Rehabilitation	<input type="checkbox"/> 132a/S&W		