

LEGAL TRANSMITTAL SHEET

YOUR COMPANY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

NAME OF ADJUSTER: _____

NAME OF INJURED WORKER: _____

SOCIAL SECURITY #: _____ - _____ - _____

NAME OF EMPLOYER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

POLICY #: _____ PERIOD: _____

CLAIM #: _____ EARNINGS: _____

T.T.D. PAID: _____ RATE: _____ PERIOD: _____ ADVANCES: _____

MEDICAL PAID: _____ DATE OF LOSS: _____

CASE # (WCAB): _____ DATE DWC-1 REC'D: _____ 5402 DATE: _____ (90 DAYS)

MEDICAL-LEGAL: _____

EMPLOYMENT PERIOD: _____ WAGE STATEMENT: **Attached** Y: **N:** _____

OCCUPATION (AS LISTED): _____ AGE: _____

HEARING DATE: _____ MSC DATE: _____ ARBITRATION DATE: _____

COMMENTS: _____

SIGNATURE: _____ DATE: _____

ISSUES
DWC-1
L.C. 5402
Q.M.E. NEEDED
A.M.E. NEEDED
COVERAGE
INJURY AOE-COE
EMPLOYMENT
OCCUPATION
PARTS OF BODY
MEDICAL-LEGAL
EARNINGS
MEDICAL-TREATMENT
L.C. 4650 D
DEATH BENEFITS
STATUTE OF LIMITATIONS
REHABILITATION
SELF PROCURED MEDICAL
JURISDICTION
OTHER

PLEASE SIGN, PRINT AND FAX THIS FORM TO THE APPROPRIATE LAW OFFICE OF GRAY & PROUTY BELOW

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