

WORKERS' COMPENSATION LITIGATION TRANSMITTAL

WALL, McCORMICK & BAROLDI

A Professional Corporation

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DATE OF HEARING

PREFERRED ATTORNEY: _____

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
REHAB. TD PAID	\$	FROM	TO PD RATE
PD PAID	\$	FROM	TO TOTAL PD ADV. \$
VRTD ATTY. FEES WITHHELD			

SUGGESTED ISSUES: (PLEASE CHECK)

<input type="checkbox"/> EMPLOYMENT	<input type="checkbox"/> FURTHER MEDICAL CARE	<input type="checkbox"/> JURISDICTION
<input type="checkbox"/> OCCUPATION	<input type="checkbox"/> SELF-PROCURED MEDICAL CARE	<input type="checkbox"/> VOCATIONAL REHABILITATION
<input type="checkbox"/> INJURY	<input type="checkbox"/> EARNINGS	<input type="checkbox"/> SUBROGATION
<input type="checkbox"/> INSURANCE COVERAGE	<input type="checkbox"/> DEPENDENCY	<input type="checkbox"/>
<input type="checkbox"/> PERMANENT DISABILITY	<input type="checkbox"/> STATUTE OF LIMITATIONS	<input type="checkbox"/>
<input type="checkbox"/> TEMPORARY DISABILITY	<input type="checkbox"/> APPORTIONMENT	<input type="checkbox"/>

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:

FROM _____ OF _____ CARRIER PHONE # _____
 ADJUSTER ADMINISTRATOR