ADELSON MCLEAN

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LITIGATION REFERRAL

Examiner Name: ____ Examiner Phone: ___________________
Company Name: ____
Address: ____
Examiner Email: ____

CASE TYPE:

☐ WORKERS' COMPENSATION ☐ SUBROGATION ☐ CIVIL LITIGATION ☐ OTHER ___________________
COURT: ____
CASE NUMBER: ____
IS THIS CASE ON CALENDAR FOR HEARING OR DEPOSITION?
DATE/TIME: ______________________ LOCATION: ______________________

CLAIMANT: ____ CLAIM NUMBER: ___________________________
CLAIMANT ADDRESS: ____
DATE OF INJURY: ________________
EMPLOYER: ____
EMPLOYER ADDRESS: ____

ATTORNEY FOR CLAIMANT: ____
ADDRESS OF ATTORNEY FOR CLAIMANT: ____

INSURANCE CARRIER: ____

HAS THIS CLAIM BEEN: ☐ ADMITTED ☐DENIED DATE COMPLAINT SERVED: ____________
DECISION DATE: ___________ DATE OF DENIAL: ___________ ANSWER DATE: ____________

BENEFITS PAID:
TEMPORARY DISABILITY: ___________ PERMANENT DISABILITY: ___________ MEDICAL: _____________

SUGGESTED ISSUES:

☐ AOE/COE ☐ TEMPORARY DISABILITY ☐ EMPLOYMENT ☐ S&W
☐ PARTS OF BODY ☐ PERMANENT DISABILITY ☐ JURISDICTION ☐ LC 132A
☐ EARNINGS ☐ COVERAGE ☐ STATUTE OF LIMITATIONS

PREFERRED ATTORNEY: __________________________
COMMENTS: ____
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