Haworth Bradshaw Stallknecht & Barber, Inc.

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Workers' Compensation Litigation Referral Sheet

Claimant_____ WCAB Case No._____
Address_____ D/Injury_____

Correct Name of Carrier/Adjusting Agency_____
Insured/Self-Insured/Legally Uninsured?_____ All Policy Periods or
Insured/Employer_____ Periods of S.I._____
Address_____

Earnings Per Week_____ Earnings Statement Attached/Requested ◯ ◯ (circle)

Benefits Paid

Temporary Disability:
Total Paid_____
Rate Paid_____
Returned to work/Date of RTW_____
Dates Paid_____
Total Medical Paid_____

Permanent Disability:
Total Paid_____
Rate Paid_____
Dates Paid_____
Total V.R. Costs Paid_____

Suggested Issues: (check)

- ☐ Employment
- ☐ Injury AOE/COE
- ☐ Insurance Coverage
- ☐ Date of Injury
- ☐ Temporary Disability
- ☐ Permanent Disability
- ☐ Earnings
- ☐ Further Medical Care
- ☐ Self-Procured Medical Care
- ☐ Medical/Legal Costs
- ☐ Jurisdiction
- ☐ Dependency
- ☐ Statute of Limitations
- ☐ Apportionment
- ☐ Occupation
- ☐ Subrogation
- ☐ Other

Original Medical Reports Are:
Attached ◯ ◯ (circle)
Filed ◯ ◯ (circle)
Served on Applicant ◯ ◯ (circle)
Medical Examination Scheduled
With (whom)_____
When (date)_____
Atty. Authorized to Schedule
Medical Examination ◯ ◯ (circle)
Deposition ◯ ◯ (circle)
Declaration of Readiness Filed ◯ ◯ (circle)
Hearing Date
Investigation Ongoing ◯ ◯ (circle)
If yes, explain:_____
Settlement Authority_____

Further Action to Be Taken/Comments:

Client_____ Examiner_____
Address_____ Telephone No._____
Claim Number(s)_____