WORKFINDERS USA

FILE REFERRAL FORM (*Permanently-Restricted)*

CLAIMANT INFORMATION

Claimant's Name: _____ Phone Number: _____

Address: _____

Physical Restrictions (please attach or state here): _____

_____

Most Current Job Title & Duties: _____

Language(s) Spoken: _____

Attorney Contact Info (include phone/fax number and email): _____

_____

YOUR INFORMATION

Name & Company: _____

Insured: _____

Phone Number: _____ Fax: _____

Email Address: _____

Mailing Address: _____

CLAIM INFORMATION

Claim # _____ State Claim # _____ AWW: _____

Indemnity Benefit Rate: _____ Date of Loss: _____ Date Reached MMI: _____

Attachments: ☐ Meds ☐ Voc Reports ☐ Resume ☐ Employment Application

Desired Hourly/Weekly Wage Sought for Claimant: _____

Defense Attorney's Contact Information (include e-mail address): _____

_____ Date of Referral: _____

Notes: _____

_____

Thank you! We will confirm receipt of referral within 2 hours.

Email - jenniferg@workfindersusa.com or nataliet@workfindersusa.com | **workfindersusa.com**