WORKFINDERS USA

FILE REFERRAL FORM *(Transitional)*

CLAIMANT INFORMATION

Claimant's Name: _____ Phone Number: _____

Address: _____

Physical Restrictions (please attach or state here): _____

_____

Most Current Job Title & Duties: _____

Known Computer Skills: _____ Language(s) Spoken: _____

Hourly Wage: _____ Authorized Treating Physician: _____

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

_____

Expected Date to RTW at Insured (if unknown, state desired length for placement): _____

Number of Hours per Week for Placement: _____ Date of Injury: _____

Maximum Distance (miles) for placement: _____

YOUR INFORMATION

Adjuster's Name: _____

Adjuster's Phone#: _____ Email:_____

Insured's Name: _____

Referrer's Name (if different from adjuster's name)_____

Employer/Insured's Name _____ Email_____

CLAIM INFORMATION

Claim # _____ Territory of Claim (US State): _____

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

_____

WORKFINDERS USA

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CLAIM INFORMATION

Date of Referral: _____

Notes: _____

_____

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

Email - lizk@workfindersusa.com or wendyr@workfindersusa.com | **workfindersusa.com**