REQUEST FOR SERVICE

COMPANY NAME:		**EMPLOYEE NAME:**	
CLAIM #	ASSIGNED BY	ADDRESS	
ADDRESS		CITY/STATE/ZIP	
CITY/STATE/ZIP		PHONE	ALTERNATE PHONE
PHONE	FAX	DATE OF INJURY	DATE OF BIRTH
Email	TYPE OF COVERAGE	OCCUPATION	Email

EMPLOYER NAME:		CONTACT PERSON
ADDRESS		PHONE
CITY/STATE/ZIP		Email
DATE OF HIRE	AVERAGE WEEKLY WAGE	COMP RATE

ATTORNEY FOR EMPLOYEE:		**ATTORNEY FOR EMPLOYER:**	
PHONE	Email	PHONE	Email

PHYSICIAN	PHONE	FAX
ADDRESS	CITY/STATE/ZIP	

TYPE OF INJURY: ____

REASON FOR REFERRAL: ____

INSTRUCTIONS & INFORMATION: ____

____

____

____

MEDICAL RECORDS: SENT ______ WILL SEND _______

DATE REC'D: ______ DATE ASGN'D: ______ REC'D BY: ______ COUNSELOR/NURSE: ____________________________

DOWNLOAD AND SAVE TO YOUR COMPUTER PRIOR TO COMPLETION.

AFTER COMPLETION, PRINT & FAX OR EMAIL TO REHABILITATION ADVISORS.