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CLAIMANT:_____ **SOC. SEC. NO:** _____

CLAIM#:_____ **DATE(S) OF INJURY:**_____

HEARING/CONFERENCE DATE:_____ **Date of Employer Knowledge:** _____

TIME: _____**PLACE:**_____**90TH DAY DEADLINE:**_____

EMPLOYER:_____**CONTACT:** _____**TITLE:** _____

COMPANY REFERRING FILE:_____

IF AN ADMINISTRATOR, NAME OF INSURANCE COMPANY:_____

ADJUSTER:_____**TITLE:**_____**POLICY PERIODS:**_____

DOES THE EMPLOYER PARTICIPATE IN A MPN? Yes [ ] No [ ]
IF IN AN MPN, WHICH MPN: _____

TD DATES PAID:_____**TOTAL PAID:**_____

PD DATES PAID:_____**TOTAL PAID:**_____

WEEKLY RATE:_____**WAGE BASIS:**_____

MEDICAL PAID:_____**MED EXAM SCHEDULED:** _____

BODY PARTS INJURED:_____

Issue		Issue	
1. AOE/COE	_____	11. Occupation	_____
2. Employment	_____	12. Apportionment	_____
3. D/Injury	_____	13. Statute	_____
4. P.D.	_____	14. Lack of Notice	_____
5. T.D.	_____	15. Fraud	_____
6. Earnings	_____	16. Subro	_____
7. Coverage	_____	17. Voucher	_____
8. Jurisdiction	_____	18. Dependency	_____
9. Treatment/UR	_____		
10. Parts of Body	_____		

CLAIMANT'S ATTORNEY:_____

REMARKS:_____