

(CLAIMANTS NAME) \_\_\_\_\_

(S.S#) \_\_\_\_\_ (D.O.B) \_\_\_\_\_

(ADDRESS)current# \_\_\_\_\_  
\_\_\_\_\_

(ADDRESS)previous# \_\_\_\_\_  
\_\_\_\_\_

(HOME PHONE) \_\_\_\_\_ (CELL PHONE) \_\_\_\_\_

(TYPE OF CASE) Investigation or Surveillance

(TYPE OF CLAIM) Work Comp or Auto Accident or Liability

(CLAIM#) \_\_\_\_\_

(DATE OF LOSS) \_\_\_\_\_

(TYPE OF INJURY) \_\_\_\_\_

(EMPLOYER) \_\_\_\_\_

(Address) \_\_\_\_\_  
\_\_\_\_\_

(Contact Source) \_\_\_\_\_

(Phone) \_\_\_\_\_ (Cell Phone) \_\_\_\_\_

(Claimant Off Work Now) Yes or No

(How Long) \_\_\_\_\_

(PERSONAL INFORMATION) Physical Description

\_\_\_\_\_  
\_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Eye Glass's: \_\_\_\_\_

Hair/Color: \_\_\_\_\_ Beard/Mustache: \_\_\_\_\_ PERS

ONAL INFORMATION CONT.) Married Yes or No

**Husband / Wife Name:** \_\_\_\_\_

**Age / Description:** \_\_\_\_\_

**Children / Ages:** \_\_\_\_\_

**Hobbies / Sports:** \_\_\_\_\_

**Places Known To Frequent:** \_\_\_\_\_

**Types Of Vehicles Driven / Owned:** \_\_\_\_\_

**(DOCTORS/PHYSICAL THERAPY INFORMATION)**

**Doctor / Clinic Name:** \_\_\_\_\_

**Address / Phone:** \_\_\_\_\_

**Appointment Schedule:** \_\_\_\_\_

**Physical Limitations / Lifting&Bending:** \_\_\_\_\_

**Using Or Wearing Any Braces / Slings etc:** \_\_\_\_\_

**Using Any Crutches / Walker etc:** \_\_\_\_\_

**(CUSTOMER REQUEST COURT RECORDS / BACKGROUND )**

**Yes or No(CUSTOMER INFORMATION)**

**Customer Name:** \_\_\_\_\_

**Company:** \_\_\_\_\_

**Address / State / Zip Code:** \_\_\_\_\_

**Phone Office:** \_\_\_\_\_ **Phone Cell:** \_\_\_\_\_

**Phone Fax:** \_\_\_\_\_

**Dollar Limit On Case & Number Of Days:** \_\_\_\_\_

**Prefer Case Worked:** (Week Days) (Week-ends) (Indicate) \_\_\_\_\_

\_\_\_\_\_ **Or** (No Preference)

**Prefer Hours Worked:** (Indicate) \_\_\_\_\_

\_\_\_\_\_ **Or** (No Preference)

**Date Case Taken:** \_\_\_\_\_

**Requested Completion Date:** \_\_\_\_\_ **Or** (No Preference)

(NOTES) \_\_\_\_\_  
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