

P.O. Box 549
Concord, CA 94522
(925) 363-3499
Fax (925) 825-3355
www.sharplegalimaging.com

Date Ordered: _____
Priority: Rush Normal
Date Needed: _____

ORDERED BY
Firm Name:
Attorney:
Address:
City, State, Zip:
Phone:
Fax:
Email:
Contact Person:
Your Client: Applicant <input type="checkbox"/> Defendant <input type="checkbox"/>

BILLING INFORMATION
Carrier Name:
Adjuster:
Address:
City, State, Zip:
Phone:
Fax:
Email:
Contact Person:

CASE INFORMATION
Applicant:
AKA:
DOB:
SSN:
Employer:
WCAB Case No.:
Date of Injury:
Claim Number:

OPPOSING PARTY
Firm Name:
Attorney:
Address:
City, State, Zip:
Phone:
Fax:
Email:
Contact Person:
SEE ATTACHED LIST OF ADDITIONAL PARTIES <input type="checkbox"/>

LOCATIONS

Location Name:
Address:
City, State, Zip:
Phone:
Medical Record, Case or File #:
Record Type(s): (select) (select) (select)
Subpoena <input type="checkbox"/> Authorization <input type="checkbox"/>
Location Name:
Address:
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Phone:
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ADDITIONAL LOCATIONS ATTACHED

ADDITIONAL INFORMATION/INSTRUCTIONS: