Regain, Inc.

JOB ANALYSIS REFERRAL

Please contact our nearest office or call: (800)743-8448 / Fax:(714)558-3035

DATE:

EMPLOYEE (CLAIMANT)

NAME:

ADDRESS:

,

PHONE: ( )

D.O.B.:

SOC. SEC. NO.:

D.O.I.:

OCCUPATION:

LANGUAGE:

INJURY TYPE:

RESTRICTIONS:

TREATING PHYSICIAN/HOSPITAL

HOSPITAL:

PHYSICIAN:

ADDRESS:

,

PHONE: ( )

FAX:

APPLICANT'S ATTORNEY

NAME:

LAW FIRM:

ADDRESS:

,

PHONE: ( )

FAX

TYPE OF REFERRAL

☐ WORKERS' COMPENSATION

☐ OTHER

CLAIMS ADMINISTRATOR

NAME/TITLE:

COMPANY:

ADDRESS:

,

PHONE: ( )

FAX ( )

CLAIM #:

EMPLOYER

NAME:

ADDRESS:

,

CONTACT PERSON:

PHONE: ( )

FAX

WORKSITE

NAME:

ADDRESS:

,

CONTACT PERSON:

PHONE: ( )

FAX

EMAIL:

DEFENSE ATTORNEY

NAME:

LAW FIRM:

ADDRESS:

,

PHONE: ( )

FAX

SEND REPORT COPIES TO:

SIGNATURE REQ'D

Yes ☐ No ☐

Yes ☐ No ☐

NOTES/SPECIAL INSTRUCTIONS: