FILE TRANSMITTAL

To: COHEN & ASSOCIATES
653 11th STREET
OAKLAND, CA 94607

From: _____

By: _____

Date: _____

File No. | Policy No. | Policy Period | Accident Date

Claimant | Claimant's Address

Employer | Employer's Address

☐ Individual ☐ Corporation ☐ Co-Partnership ☐ Joint Venture ☐ Other (Explain Below)

Temporary Paid | Rate | Periods Covered | Medical Paid

Permanent Paid | Rate | Periods Covered | Advancement Paid | Periods Covered

Wage Basis | Occupation

☐ Permanent ☐ Part-Time ☐ Seasonal ☐ Temporary ☐ Casual ☐ Other (Explain)

Application Date | WCAB No. | Hearing Date | Hearing Location (e.g. OAK, SFO)

Claimant's Attorney | Attorney's Address

Suggested Issues:
☐ Injury ☐ Employment ☐ Occupation ☐ Coverage
☐ Earnings ☐ Temporary Disability ☐ Permanent Disability ☐ Apportionment
☐ Past Medical ☐ Future Medical ☐ Statute of Limitations ☐ Jurisdiction
☐ Dependency ☐ Other (Explain)

Action Pending:
☐ Medical Examination ☐ Investigation ☐ Wage Statement ☐ Employer Statement
☐ Other (Explain)

Medical Reports Filed and Served: ☐ Yes ☐ No (If No, please furnish original and two copies of all reports)

Remarks and Instructions:

_____
_____
_____
_____
_____
_____