THE SIMON GROUP
VOCATIONAL REHABILITATION COUNSELORS

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Referral Form

Referring Attorney: ____

Referral Type: Le Boeuf ☐ **DFEC** ☐ **Other** ☐

Please specify any special requests, upcoming deadlines etc. ________________

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Applicants Name: ____

Applicant's Address (please include city, state, zip): _________________________

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Employer: ____

DOI: ____

WCAB/EAMS#: ____

Claim #: ____

Applicant Attorney's Name: ____

Address (please include city, state, zip): _________________________________

____

Telephone number: ____

Email Address: ____

Def. Attorney's Name: ____

Address (please include city, state, zip): ______________________________

____

Telephone number: ____

Email Address: ____

Insurance Company Name: ____

Name of Adjuster: ____

Adjusters telephone number: ____

Insurance Company Address (please include city, state, zip): ________________

____

Email Address: ____

Medical Records: Mailed ☐ Emailed ☐ Other ☐ ________________________

Interpreter Needed? _________ **If so, language:** __________________

Will your office be setting up interpreter services? _______________

Comments: ____