

CASE INITIATION DOCUMENT

TYPE OF ACTION (CHECK ONE)

- Initial Filing
 Address Change
 Employee/Employer Atty. Firm Change
 Adjusting Agency Change

INSTRUCTIONS: This form shall be completed and attached to all requests for Rehabilitation Unit action on matters for which no Rehabilitation Unit Case number has been assigned. This form is also to be used to update address changes for any of the parties or to record changes in representation for either the employer or employee and any change of adjusting agency. This form must be typed or printed clearly and submitted to the appropriate Rehabilitation Unit office. See reverse side for Rehabilitation Unit address.

EMPLOYEE NAME: (LAST) (FIRST) (M.I.) SEX:

ADDRESS: (STREET) (CITY) (STATE) (ZIP)

DATE OF BIRTH: PHONE #: SOCIAL SECURITY #: DATE OF INJURY:

EMPLOYER NAME: _____ DWC ID # (if known): _____

MAILING ADDRESS (incl. City, State & Zip): _____

SELF INSURED CERTIFICATE NAME: _____

INSURANCE CARRIER (if any): _____

ADJUSTING AGENCY NAME (if agency adjusted): _____

CLAIMS MAILING ADDRESS (incl. City, State & Zip): _____

PHONE : _____ CLAIM #: _____

QUALIFIED REHAB REPRESENTATIVE, IF ANY

FIRM NAME: _____ REPRESENTATIVE NAME: _____

MAILING ADDRESS (incl. City, State & Zip): _____

PHONE: _____ DWC FIRM # (if known): _____

EMPLOYEE'S REPRESENTATIVE, IF ANY

FIRM NAME: _____ REPRESENTATIVE NAME: _____

MAILING ADDRESS (incl. City, State & Zip): _____

PHONE #: _____ DWC FIRM # (if known): _____

EMPLOYER'S REPRESENTATIVE, IF ANY

FIRM NAME: _____ REPRESENTATIVE NAME: _____

MAILING ADDRESS (incl. City, State & Zip): _____

PHONE #: _____ DWC FIRM # (if known): _____

SUBMITTED BY: _____

TITLE: _____

DATE: _____

REHABILITATION UNIT USE ONLY