



ARS
 (111) 611-1111 FAX: (111) 611-1111
 P.O. Box 3399, Torrance, CA 90503

Admitted Injury <input type="checkbox"/> Yes <input type="checkbox"/> No	Trial Date:	<input type="checkbox"/> WCAB <input type="checkbox"/> CIVIL
	Request Date:	<input type="checkbox"/> RUSH:
Date of Letter Of Rep. Received	Due Date:	(Reason, ie. Trial, AME, MSC, etc.)

1. COPY RECORDS PERTAINING TO

Name: _____ AKA: _____ Injury Date(s): _____
 Address: _____ Phone: _____ SSN: _____ DOB: _____

2. REQUESTOR

Firm: _____
 Address: _____
 Phone: _____ Fax: _____
 Attorney: _____
 Bar No: _____
 Contact: _____
 Representing: Plaintiff/Applicant Defendant
 Other:

3. BILLING INFORMATION

Send Invoice To: Requestor Carrier (provide detail below)
 Carrier: _____
 Address: _____
 Phone: _____
 Adjustor: _____ Ext: _____
 Claim No: _____
 Employer / Insured: _____
 Address: _____

4. SUBPOENA INFORMATION

Case No: _____
 Case Caption: _____
 vs: _____
 County: _____
 Judicial District: _____
 Request Type: SUP MUN FED ARB WCAB
 Authorization Attached Client Subpoena
 Prepare: Deposition Subpoena Trial Subpoena
 Discovery Cutoff Date: _____
 For: Records Only
 Personal Appearance WITH Records
 Personal Appearance WITHOUT Records
 Appearance Address: _____
 Date: _____ Time: _____
 Dept/Div: _____

Additional Carrier List Attached

5. OPPOSING COUNSEL

Counsel: _____
 Firm: _____
 Address: _____
 Phone: _____
 Representing: Plaintiff/Applicant Defendant
 Other:

Additional Counsels List Attached

6. DELIVERY INSTRUCTIONS

Requestor Qty Paper: Duplex: CD:
 Other Qty Req'd Paper: Duplex: CD:
 Name/Address: _____

Additional Delivery List Attached

7. OBTAIN RECORDS FROM (Use codes below to designate what records are needed from each location)

Codes: [M]edical [B]illing [X]-ray Films [E]mployment [W]age [C]laim File [O]ther:

Code	Location Name	Address	Phone	Treat Date(s)

Additional Copy Locations Attached Copy: Any and All These Dates Only:

Special Instructions (attach claim or application form): _____