Mirfak Associates, Inc.
Intake Form (Workers' Comp.)

Attorney Name: _____

Firm Name: _____

Address: _____

Telephone: _____Fax:_____

E-mail:_____

Applicant Name: _____

ADJ #: _____

Claim #: _____

Type of referral: (please mark one)

Defense ____ Applicant ____

Brief description of services requested:

_____

_____

Date of Injury: _____ Trial Date: _____

Completed by: _____

Direct telephone number of person completing the form: _____

A Mirfak Associates, Inc. representative will contact you within 24 hours to schedule an evaluation appointment with one of our vocational rehabilitation consultants.