Post Office Box 120
Simi Valley CA 93062

S.D.T. SERVICES

RECORD REQUEST FORM

TELEPHONE: (805) 581-0031
FACSIMILE: (805) 522-3561
E-MAIL: sdt1@sbcglobal.net
WEBSITE: www.recordrequest.com

DATE OF REQUEST:____________________

YOUR COMPANY INFORMATION

REQUESTED BY:	COMPANY NAME:
ADDRESS:	PHONE NUMBER:
CITY:	FAX / E-MAIL:

CASE INFORMATION

EMPLOYER:	CLAIM NUMBER:
DATE OF INJURY:	WCAB NUMBER:

CLAIMANT INFORMATION

CLAIMANT NAME:	AKA NAME (IF ANY):
ADDRESS:	DATE OF BIRTH:
CITY:	SOCIAL SECURITY #:

APPLICANT'S COUNSEL INFORMATION	DEFENSE COUNSEL/CARRIER INFORMATION
NAME:	NAME:
ADDRESS:	ADDRESS:
CITY: PHONE:	CITY: PHONE:

SPECIFIC WORK REQUESTED

☐ COPY RECORDS ☐ PREPARE SUBPOENA DUCES TECUM ☐ AUTHORIZATION ENCLOSED ☐ RUSH – DATE NEEDED_______________

☐ SERVE SUBPOENA TO APPEAR: DATE _________________TIME__________CITY___________________________JUDGE_______________________

OBTAIN RECORDS FROM/WITNESS INFORMATION (Please include street address and telephone number)

☐ MEDICAL ☐ EMPLOYMENT ☐ X-RAYS ☐ CLAIMS FILE#	☐ MEDICAL ☐ EMPLOYMENT ☐ X-RAYS ☐ CLAIMS FILE#
NAME:	NAME:
ADDRESS:	ADDRESS:
CITY: PHONE:	CITY: PHONE:
☐ MEDICAL ☐ EMPLOYMENT ☐ X-RAYS ☐ CLAIMS FILE#	☐ MEDICAL ☐ EMPLOYMENT ☐ X-RAYS ☐ CLAIMS FILE#
NAME:	NAME:
ADDRESS:	ADDRESS:
CITY: PHONE:	CITY: PHONE:
☐ MEDICAL ☐ EMPLOYMENT ☐ X-RAYS ☐ CLAIMS FILE#	☐ MEDICAL ☐ EMPLOYMENT ☐ X-RAYS ☐ CLAIMS FILE#
NAME:	NAME:
ADDRESS:	ADDRESS:
CITY: PHONE:	CITY: PHONE:
☐ MEDICAL ☐ EMPLOYMENT ☐ X-RAYS ☐ CLAIMS FILE#	☐ MEDICAL ☐ EMPLOYMENT ☐ X-RAYS ☐ CLAIMS FILE#
NAME:	NAME:
ADDRESS:	ADDRESS:
CITY: PHONE:	CITY: PHONE:

SPECIAL INSTRUCTIONS:____

ADDITIONAL SET(S)________ SENT TO:_______________________________________