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WORK ORDER FORM
Medical/Business Record Copying

Date of Request _____
Requesting Attorney/Facility _____
Address _____
Phone# _____ **Fax#** _____

Name and location of medical/business facility

_____
_____

Physician Name _____
Phone # _____ **Fax#** _____

Patient/Client Name: _____

Date of Birth: _____ **SSS#** _____

Date of Injury: _____

****Please include authorization/release from claimant with your order.**

****Special Instructions:**

THANK YOU FOR YOUR ORDER!