Professional Medical Copies, Inc.

RECORDS PREPARATION SERVICE REQUEST

Injured party: **Date of Injury:**

Claim Number: **W.C. Number:**

Ins. Co: **Claim Rep:**

Claim Rep Phone #: **E-Mail:**

Claimant or Attorney: **phone:**

Address:

City, State, Zip:

Defense Counsel: **phone:**

Address:

City, State, Zip:

Please indicate the type of evaluation being performed:

☐ NEW TREATING DOCTOR Physician:

☐ I.M.E. Address:

☐ SECOND OPINION

☐ PEER REVIEW Phone:

☐ CASE SUMMARY Appoint. Date/Time:

☐ MEDICAL CHRONOLOGY

Send Records to:	Preferred format:	hard copy	disk	encrypted email
☐	Doctor:	☐	☐	☐
☐	Claimant or Attorney:	☐	☐	☐
☐	Carrier Attorney:	☐	☐	☐
☐	Claim Representative:	☐	☐	☐

Special Instructions or concerns with this case:

*****To transmit your records to us electronically, you may send them via encrypted email to mary@promedcopies.com, or request a link to our secure upload portal.**

PMC Signature:_____**Date**:_____**Page Count:**_____

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