



APPLEBY & CO. INC

RUSH – Date Needed by: _____

Authorization or Subpoena

Please deliver records via: Paper CD Website

Attorney Firm: _____

Address: _____

City, St, Zip: _____

Secretary: _____

Email: _____

Phone #: _____

Attorney: _____

Representing: Defendant or Plaintiff/Applicant

Date of Loss: _____

Case Title: _____

Municipal Court Superior Court WCAB

Case #: _____

Records Re: _____

DOB: _____

Billing Information (if different):

Company: _____

Address: _____

City, St, Zip: _____

Adjuster: _____

Email: _____

Phone #: _____

Insured Name: _____

Claim #: _____

District: _____

If WCAB # is Unassigned – Application is Required

AKA: _____

SSN: _____

Custodian of Records/Name/Entity

Address

Phone #

1. _____

Type of Records: Bills Medical Employment Insurance Claim File Insurance Policy
 Other: _____ X-Rays -or- Subpoena x-rays, but do not copy at this time

2. _____

Type of Records: Bills Medical Employment Insurance Claim File Insurance Policy
 Other: _____ X-Rays -or- Subpoena x-rays, but do not copy at this time

3. _____

Type of Records: Bills Medical Employment Insurance Claim File Insurance Policy
 Other: _____ X-Rays -or- Subpoena x-rays, but do not copy at this time

4. _____

Type of Records: Bills Medical Employment Insurance Claim File Insurance Policy
 Other: _____ X-Rays -or- Subpoena x-rays, but do not copy at this time

Opposing Counsel/Pro Per (if injured party does not have an attorney, provide home address):

Firm: _____

Address: _____

City, St, Zip: _____

Phone #: _____

Attorney: _____

Representing: _____

Forward a Set of Records: Yes or No

If Yes, Paper, CD or Web

Other Parties:

Firm: _____

Address: _____

City, St, Zip: _____

Phone #: _____

Attorney: _____

Representing: _____

Forward a Set of Records: Yes or No

If Yes, Paper, CD or Web

Special Instructions: _____