

[Please Add Practice Name & Address]

VERIFICATION FORM – ATTORNEY

Patient's Name: _____ Date of Accident: ___/___/___

Attorneys Name: _____ City or Phone: _____

Is the attorney representing the PT for the accident **which occurred on the above date** YES NO

If I send a letter of protection form to your attention, can you please see to it that the attorney signs and sends it back to my attention? YES NO

(If we don't have the attorney's address in our computer system) **Get the Attorney's Address:**

Name of Law Firm: _____

Street (street is preferable): _____

City, State, Zip: _____

Phone: (____) _____ Fax: (____) _____

Initials: _____ Date: ___/___/___ Spoke with: _____

Checklist for an attorney letter has been completed Y N/A

NOTES