

Sean Ditty INVESTIGATIONS

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<input type="checkbox"/> Surveillance	Date Assigned:	# of Days
<input type="checkbox"/> Activity Check	Due Date:	# of Days
<input type="checkbox"/> Background	Other	
<input type="checkbox"/> AOE/COE	SDI Internal #	

INVESTIGATION ORDER FORM

Claimant:		D.O.B.	Age:	SSN:	
Address:					
City:	State:	Zip:	Home Phone:	Cel Phone:	
Vehicle Year:	Vehicle Make:	Model:	Lic. Plate:	Drivers Lic.:	
Are benefit checks mailed to the above address?		If no; Where are they sent:			
Physical Description:			Physical Marks:		
Sex: Male / Female	Hair Color:	Eye Color:	Race:	Height:	Weight:
Injury/Illness:		Physical Restrictions:			
Date of injury:	Occupation:	Employer Phone:		Contact Person:	
Employer:		Employer Address:			
Is it acceptable for our investigator to contact the employer's contact person or representative in this matter? Yes / No					
Are there any photographs available of the claimant? Yes / No			Does the claimant have a doctor's appointment in the near future? Yes / No		

If yes; Please provide the name of the doctor and the date of the next appointment below

Doctor's Name:		Doctor's Address:			
City:		Date/Time Appointment:			
Special Instructions:					
Claims Agent:		Company:		Claim # for case:	
Email:		Phone:		Fax:	