

REQUEST FORM

CENTRIC INVESTIGATION SERVICES INC.

Fax: 905-882-8336 or Email: assignment@centricinvestigation.ca

REQUESTER

Last Name _____
First Name _____
Company Name _____
Address _____

City _____
Province _____ Postal Code _____

Direct Tel No. _____
Fax No. _____
Email Address _____
Reference / Claim No. _____
Insured _____
Principals _____
\$ Budget / No. of Days _____

SUBJECT OF INVESTIGATION

First Name _____
Last Name _____
Address _____

City _____
Province _____ Postal Code _____
Telephone No. _____
Date of Birth _____
Driver's Lic. No. _____

Date of Loss _____
Type of Loss _____
Type of Injury _____

Physical Description _____

Marital Status _____
Spouse's Name _____
Children & Ages _____

EMPLOYER, INSURANCE COMPANY, MEDICAL

Employer's Name _____
Occupation _____
Address _____

City _____
Province _____ Postal Code _____
Employer's Tel. _____
Claimant's Insurer _____
Policy Number _____

Adjuster _____
Physician _____
Physician's Address _____

Physiotherapist _____
Physio Address _____

Previous Investigation YES _____ NO _____
Attorney _____

VEHICLE

Make _____ Model _____ Colour _____ Year _____ Licence Plate _____
Make _____ Model _____ Colour _____ Year _____ Licence Plate _____

Requester Instructions:

Call to Discuss YES _____ NO _____