T2 INSURANCE
— SOLUTIONS LLC —

YOUR
WORKERS
COMPENSATION
SOURCE

Claims Activity Log

Claimant Name: _____ Claim #:_____
Claimant Address:_____
City, State, Zip:_____
Work Phone:_____Home Phone:_____Cell Phone:_____
Branch Location:_____
Date of Accident:_____Date Reported to Client:_____
Date Reported to Branch:_____Date Reported to Carrier:_____
Date of Modified Release:_____Date of Full Release:_____
Modified Workdays:_____Lost Work Days:_____

Client Location:_____
Workers Compensation Code:_____
Accident Description: _____
_____

Adjuster's Name:_____Adjuster's Phone Number:_____
Adjuster's Email Address:_____

Doctor's Name:_____Doctor's Phone Number:_____
Doctor's Email Address:_____

Attorney's Name:_____Attorney's Phone Number:_____
Attorney's Email Address:_____