



EXPERT REPORT REQUEST FORM

Attorney Name: _____

Client Name: _____

Phone: _____

DOB: _____ DOI: _____

E-Mail: _____

Address: _____

REQUESTED COMPLETION DATE:

Phone: _____

E-Mail: _____

REPORTS:

(PLEASE CHECK ALL THAT APPLY)

☐ Expert Medical Opinion Report w/ Future Care

☐ Expert Trauma (PTSD) Report

___ Pain Medicine (Spine)

☐ Economic Loss

___ Neurology

☐ Present Value

___ Extremity Orthopedics

Please return this form to mike@foresightexpertsolutions.com

EXPERT REQUEST AGREEMENT:

Foresight Expert Solutions (FES) agrees to complete all work by the requested deadlines. Any necessary changes will be discussed and agreed upon by FES and the requesting legal entity.

The requesting legal entity agrees to pay all invoices by the agreed upon date.

Legal entity authorized signature: _____ Date: _____