CASE SUMMARY

GENERAL INFORMATION

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400 Cornerstone Drive Suite 310, PO Box 1660 Williston, Vermont 05495 (802)878-0346 Fax: (802)878-0876

GENERAL INSTRUCTIONS

This form is provided to facilitate Economic & Policy Resources' economic assessment of your case. Please complete the information below and the sections attached and return to EPR along with the additional requested file documentation. Please identify any information that is to be considered "Attorney work product" by marking on the cover sheet.

CASE INFORMATION				
Case Reference:		<i>.</i>		
Court of Jurisdiction:				
Tried under the laws of the sta	te of:			
Subjects Name:	Date	of Accident/Action:		
Subject is: (check one)	aintiff Defendant Type o	f Action: Personal Ir	njury Wrongful Death C	Other
Brief Description of Case:				
ATTORNEY INFORMATION				
Lead Attorney:		Email:		
Name of Firm:				
Address:				
City, State & Zip:				
Telephone # :				
Case Schedule:				
Form Completed by:		Phone# :	Ext#:	
OTHER				
The forms checked below are	enclosed. They should be	completed and returns	ed with this cover sheet.	
BIOGRAPHICAL DATA EMPLOYMENT HISTOR ADDITIONAL INFORMA	RY	(if applicable)	RMATION REQUEST	



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SUBJECT'S BIOGRAPHICAL DATA

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Case Reference:		V	
IN	STRUCTIO		
Complete the following line items. Please atta Spouse's Information Request page if applical		l pages as necessa	ry. Please complete the
Subject's Name:	Gender:	R	lace:
DOB: Occupation:			
Place of Residence:			
Educational Attainment (indicate grade level last	completed):		Year Completed:
Marital Status:	Spouse Na	me·	
Date of Marriage:	Spouse DC)B:	
If wrongful death, date of death:	openee 2 c		
SURVIVING DEPENDENTS			
Name: DOB: Relation	onship:	Dependent:	Living in Household:
HOUSEHOLD STATUS			
Did the subject maintain a household prior to t	he accident?)	
If a personal injury, does the subject currently	maintain a h	ousehold?	
Has the injury changed the manner in which the			
Does the injury currently affect the subject's at	bility to main	tain the household?	
SUBJECT'S GENERAL HEALTH	A		
Smoker?	Amount pe	r day:	
Year subject quit smoking: Does the subject have a history of heart disease	502	Data of Diag	anosis:
Date of last episode:			
			gnosis:
Type of Diabetes:			gee.e
Pre-existing chronic health conditions:			
Please indicate any of the subject's disabilities, illne	esses, depend	lencies, etc. that may	be relevant to the case.
house home and the state of			
INJURY INFORMATION (for personal injury cases	s only)		
Type of Accident/Injury: Nature of Injury:			
Was the subject hospitalized due to injury?			
Since the injury has the subject received medi	cal or rehab	_ litative care?	
	cai oi iciiai	וונמנועכ למוכי	



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SUBJECT'S EMPLOYMENT HISTORY

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CASE REFERENCE:			V		
Detail Subject's past 10 necessary.		STRUCT Begin wi		employer. A	Add additional pages if
SELF EMPLOYMENT DA	ATA				
Company Name: Occupational Title: Year company started:					
Net profits for the last 5 years:	Year: Year:	Net Reve Net Reve Net Reve Net Reve Net Reve	nues\$: nues\$: nues\$:	No.	et Profit\$: et Profit\$: et Profit\$: et Profit\$: et Profit\$:
If personal Injury: Has the subject returned Has the subject returned Has subject began to pr At what age does/did the	d to work with less eque repare for retirement?	al or mor			
Company Name:			Job Title:		
Work Address:		City	10.	State:	Zip:
Employment Contact:		City:	Telephone #:	State:	Zip. _ Fax #:
Address:					
Wage Rate: Pay Period:					
If hourly, how many hours normally worked? (annual, monthly, weekly, hourly) How many hours overtime:					
Overtime Rate: Union Employment:	Number of r				
Fringe benefits received	1: (health insurance, pe	ongian naid	vacations other)		
Nature of work performe		erisiori, paid	vacations, other)		
If personal Injury: Has the subject returned Has the subject returned Has subject began to pr At what age does/did th	d to work with less eque repare for retirement?	al or mor	e hours than prid	Date Re or to injury?	



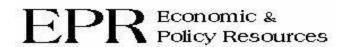
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SUBJECT'S EMPLOYMENT HISTORY CONTINUED

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Job Title:	
	State: Zip:
Tolophono #:	 Fax #:
Pay Period:	
	onthly, weekly, hourly*)
ly worked? How m	nany hours overtime:
Number of months at work	during each year:
	· · · · · · · · · · · · · · · · · · ·
surance, pension, paid vacations, other	r)
To:	
	State: Zip:
Telephone #:	Fax #:
Pay Period:	
·	onthly, weekly, hourly*)
	nany hours overtime:
Number of months at work during	each year:
insurance, pension, paid vacations, of	ner)
loh Title:	
	State: Zip:
	State Zip Fax #:
i eleptione #.	Ι αλ π.
Pay Period:	
r ay r enou(annual. mo	onthly, weekly, hourly*)
	ny hours overtime:
	·
Trainsol of months at work during	
insurance pension paid vacations of	her)
modicinos, pondion, paid vadations, ot	,
	City: Telephone #: Pay Period: (annual, mo (annual,



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SPOUSE'S INFORMATION REQUEST

(if applicable)

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CASE REFERENCE:	V	
INST		
Complete the following line items. Please attach	additional pages as ne	cessary.
Spouse's Name:	ander:	Pace:
Spouse's Name: Ge DOB: Occupation:		Race.
Place of Residence:		
Educational Attainment: (indicate grade level last co	mpleted) Year Complete	d:
	Tour complete	u
SPOUSE'S GENERAL HEALTH		
Smoker?	Amount per day:	
rear spouse duit smoking.	_	
Does the spouse have a history of heart disease?	Da	te of Diagnosis:
Date of last episode: Are Does spouse have a history of Diabetes?	medications taken?	-(Diamara)
Does spouse nave a history of Diabetes?	Date	of Diagnosis:
Type of Diabetes: Pre-existing chronic health conditions:	Controlled by:	
Please indicate any of the spouse's disabilities, illnesse	es denendencies etc tha	t may be relevant to the case
ricase indicate any or the spouse s disabilities, limesse	o, dependencies, etc. the	thay be relevant to the case.
EMPLOYER I		
(If necessary, include a separate sheet detailing Company Name:		
Company Name:	Job Title:	.,
Company Name:	Job Title:	•
Company Name: From: Work Address: Cit	Job Title:	•
Company Name: From: Work Address: Employment Contact:	Job Title: To: ty: Telephone #:	State: Zip: Fax #:
Company Name: From: Work Address: Employment Contact:	Job Title: To: ty: Telephone #:	State: Zip: Fax #:
Company Name: From: Work Address: Employment Contact: Address: Wage Rate:	Job Title: To: ty: Telephone #: Pay Period: (annumannumannumannumannumannumannumannu	State: Zip:
Company Name: From: Work Address: Employment Contact: Address: Wage Rate: *If hourly, how many hours normally worked?	Job Title: To: ty: Telephone #: Pay Period: (annu	State: Zip: Fax #:
Company Name: From: Work Address: Employment Contact: Address: Wage Rate: *If hourly, how many hours normally worked? Overtime Rate: Number of montage.	Job Title: To: ty: Telephone #: Pay Period: (annu	State: Zip: Fax #:
Company Name: From: Work Address: Employment Contact: Address: Wage Rate: *If hourly, how many hours normally worked? Overtime Rate: Union Employment: Number of montage in the company of the company in the company	Job Title: To: ty: Telephone #: Pay Period: (annu	State: Zip: Fax #:
Company Name: From: Work Address: Employment Contact: Address: Wage Rate: *If hourly, how many hours normally worked? Overtime Rate: Union Employment: Fringe benefits received:	Job Title: To: ty: Telephone #: Pay Period: (annu How many h	State: Zip: Fax #:
Company Name: From: Work Address: Employment Contact: Address: Wage Rate: *If hourly, how many hours normally worked? Overtime Rate: Union Employment: Fringe benefits received: (health insurance, pension)	Job Title: To: ty: Telephone #: Pay Period: (annu How many h	State: Zip: Fax #:
Company Name: From: Work Address: Employment Contact: Address: Wage Rate: *If hourly, how many hours normally worked? Overtime Rate: Union Employment: Fringe benefits received:	Job Title: To: ty: Telephone #: Pay Period: (annu How many h	State: Zip: Fax #:al, monthly, weekly, hourly*)
Company Name: From: Work Address: Employment Contact: Address: Wage Rate: *If hourly, how many hours normally worked? Overtime Rate: Union Employment: Fringe benefits received: (health insurance, pension)	Job Title: To: ty: Telephone #: Pay Period: How many hearths at work during each yearth on, paid vacations, other)	State: Zip: Fax #:
Company Name: From: Work Address: Employment Contact: Address: Wage Rate: *If hourly, how many hours normally worked? Overtime Rate: Union Employment: Fringe benefits received: Nature of work performed: If personal Injury: Has spouse experienced diminished earnings due	Job Title: To: ty: Telephone #: Pay Period: How many hearths at work during each yearth on, paid vacations, other)	State: Zip: Fax #:
Company Name: From: Work Address: Employment Contact: Address: Wage Rate: *If hourly, how many hours normally worked? Overtime Rate: Union Employment: Fringe benefits received: Nature of work performed: If personal Injury: Has spouse experienced diminished earnings due	Job Title: To: ty: Telephone #: Pay Period: How many hearths at work during each yearth on, paid vacations, other)	State: Zip: Fax #:
Company Name: From: Work Address: Employment Contact: Address: Wage Rate: *If hourly, how many hours normally worked? Overtime Rate: Union Employment: Fringe benefits received: Nature of work performed: If personal Injury: Has spouse experienced diminished earnings due	Job Title: To: ty: Telephone #: Pay Period: How many hearths at work during each yearth on, paid vacations, other)	State: Zip: Fax #:
Company Name: From: Work Address: Employment Contact: Address: Wage Rate: *If hourly, how many hours normally worked? Overtime Rate: Union Employment: Fringe benefits received: (health insurance, pension Nature of work performed: If personal Injury: Has spouse experienced diminished earnings due	Job Title: To: ty: Telephone #: Pay Period: How many hearths at work during each yearth on, paid vacations, other)	State:Zip:



ADDITIONAL INFORMATION

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Case Reference:	V
OTHER EXPERTS WORKING ON THIS CASE	
Indicate the name, address, and telephone number of c may need to be contacted or whose opinion may assist necessary.	

ADDITIONAL INFORMATION

Please provide copies of the information or documents listed below, if they are available.

Copy of Complaint

Deposition of Plaintiff - if any

Deposition of Expert(s) – Including Plaintiffs Doctors and Life Care Plan (if any)

Report of Medical Expert(s)

Report of Vocational Rehabilitation Expert(s) including Plaintiffs Vocational/Life Care Plan Report (For Personal Injury Cases Only) – if available

Copy of relevant responses to interrogatories

Copies of Income Tax Filing(s) (including W-2 or Schedule C)
Include Copies for the years 5 years prior to accident; then to present

Employment Information

- employer's personnel file
- employers wage and earings records
- employee evalutation form(s)
- employer's statement of employee's retirement benefits
- union contract (if applicable)

Other

Social security earnings history (http://www.eprlegaleconomics.com/assets/Uploads/ Answers to interrogatories Social-Security-Request-Form-2011.pdf)



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CHILD'S BIOGRAPHICAL DATA

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CASE REFERENCE:	V		
Carofully complete the following	INSTRUCTIONS		20. 20. 000000000
Carefully complete the following	g items. Piease attac	п айишопат раде	es as necessary.
Child's Name: DOB: Occupa	Gender:	Ra	
Place of Residence:			
Educational Attainment: (indicate grade leve	el last completed)		Year Completed:
Marital Status: NA	Spouse Name:	NA	_
Date of Marriage: NA	Spouse DOB:	NA	
If wrongful death, date of death: (if differe		ent) NA	
,		, 	
SURVIVING DEPENDENTS			
Name: DOB: R	elationship:	Dependent:	Living in Household:
NA			
HOUSEHOLD STATUS			
Did the child maintain a houshold prior to			
If a personal injury, does the child current	ly maintain a househ	old?	
Has the injury changed the manner in wl	hich the household is	maintained?	
Does the injury currently affect the child'	s ability to maintain th	ne household?	
CHILD'S GENERAL HEALTH			
	Amount per day	y:	
Year child quit smoking:			
Does the child have a history of heart dise			nosis:
	Are medications		
Does the child have a history of Diabetes		Date of Diag	nosis:
Type of Diabetes:	Cont	rolled by:	
Preexisting chronic health conditions:			
Please indicate any of the child's disabilities, il	Inesses, dependencies	, etc. that may be r	elevant to the case.



CHILD'S BIOGRAPHICAL DATA

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CASE REFERENCE:		v		
Carefully complete the followi	INSTRUCTIONS	_	ditional page	s as necessary.
•	Gender:			-
DOB: Occup	pation:			
Place of Residence:				
Educational Attainment: (indicate grade le	vel last completed)			Year Completed:
Marital Status: NA	Spouse Name	e: _	NA	
	Spouse DOB:	_	NA	
If wrongful death, date of death: (if differ	ent from date of accid	dent) _	NA	
SURVIVING DEPENDENTS				
	Relationship:	De	ependent:	Living in Household:
NA	,		•	
HOUSEHOLD STATUS				
Did the child maintain a houshold prior to	o the accident?			
If a personal injury, does the child curren		hold?		
Has the injury changed the manner in v			itained?	
Does the injury currently affect the child	d's ability to maintain	the ho	usehold?	
CHILD'S GENERAL HEALTH				
Smoker/Non-Smoker:	Amount pe	er day:		
Year child quit smoking:		-	Data of Diagra	
Does the child have a history of heart did Date of Last episode:	Are medication	L	Date of Diagr	nosis:
Does the child have a history of Diabete				nosis:
Type of Diabetes:		ntrolled	bv:	10313.
Preexisting chronic health conditions:		0.1.00	~,·	
Please indicate any of the child's disabilities,	illnesses, dependencie	es, etc. t	hat may be re	elevant to the case.

