CASE SUMMARY

GENERAL INFORMATION

Economic & Policy Resources
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: _____ v. _____

Court of Jurisdiction: _____

Tried under the laws of the state of: _____

Subjects Name: _____ Date of Accident/Action: _____

Subject is: (check one) ☐ Plaintiff ☐ Defendant Type of Action: ☐ Personal Injury ☐ Wrongful Death ☐ Other

Brief Description of Case: _____

ATTORNEY INFORMATION

Lead Attorney: _____ Email: _____

Name of Firm: _____

Address: _____

City, State & Zip: _____ _____ _____

Telephone # : _____ Fax: _____

Case Schedule: _____

Form Completed by: _____ Phone# : _____ Ext#: _____

OTHER

The forms checked below are enclosed. They should be completed and returned with this cover sheet.

- ☑ BIOGRAPHICAL DATA
- ☑ EMPLOYMENT HISTORY
- ☑ ADDITIONAL INFORMATION

Also include:

- ☐ SPOUSE'S INFORMATION REQUEST (if applicable)
- ☐ CHILDREN'S INFORMATION REQUEST

SUBJECT'S BIOGRAPHICAL DATA

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CASE REFERENCE: _____ v. _____

INSTRUCTIONS

Complete the following line items. Please attach additional pages as necessary. Please complete the Spouse's Information Request page if applicable.

Subject's Name: _____ Gender: _____ Race: _____
DOB: _____ Occupation: _____
Place of Residence: _____

Educational Attainment (indicate grade level last completed): _____ Year Completed: _____

Marital Status: _____ Spouse Name: _____
Date of Marriage: _____ Spouse DOB: _____
If wrongful death, date of death: _____

SURVIVING DEPENDENTS

Name:	DOB:	Relationship:	Dependent:	Living in Household:

HOUSEHOLD STATUS

Did the subject maintain a household prior to the accident? _____
If a personal injury, does the subject currently maintain a household? _____
Has the injury changed the manner in which the household is maintained? _____
Does the injury currently affect the subject's ability to maintain the household? _____

SUBJECT'S GENERAL HEALTH

Smoker? _____ Amount per day: _____
Year subject quit smoking: _____
Does the subject have a history of heart disease? _____ Date of Diagnosis: _____
Date of last episode: _____ Are medications taken? _____
Does subject have a history of Diabetes? _____ Date of Diagnosis: _____
Type of Diabetes: _____ Controlled by: _____
Pre-existing chronic health conditions:
Please indicate any of the subject's disabilities, illnesses, dependencies, etc. that may be relevant to the case.

INJURY INFORMATION *(for personal injury cases only)*

Type of Accident/Injury: _____
Nature of Injury: _____
Was the subject hospitalized due to injury? _____
Since the injury has the subject received medical or rehabilitative care? _____
Is the subject currently receiving medical or rehab. care? _____

SUBJECT'S EMPLOYMENT HISTORY

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CASE REFERENCE: _____ v. _____

INSTRUCTIONS

Detail Subject's past 10 years of work history. Begin with most recent employer. Add additional pages if necessary.

SELF EMPLOYMENT DATA

Company Name: _____
Occupational Title: _____
Year company started: _____

Net profits for the last 5 years:

Year: _____	Net Revenues$: _____	Net Profit$: _____
Year: _____	Net Revenues$: _____	Net Profit$: _____
Year: _____	Net Revenues$: _____	Net Profit$: _____
Year: _____	Net Revenues$: _____	Net Profit$: _____
Year: _____	Net Revenues$: _____	Net Profit$: _____

If personal Injury:
Has the subject returned to work since the accident? _____ Date Returned: _____
Has the subject returned to work with less equal or more hours than prior to injury? _____
Has subject began to prepare for retirement? _____
At what age does/did the subject expect to retire? _____

EMPLOYER I

Company Name: _____ Job Title: _____
From: _____ To: _____
Work Address: _____ City: _____ State: _____ Zip: _____
Employment Contact: _____ Telephone #: _____ Fax #: _____
Address: _____
Wage Rate: _____ Pay Period: _____
(annual, monthly, weekly, hourly*)

*If hourly, how many hours normally worked? _____ How many hours overtime: _____
Overtime Rate: _____ Number of months at work during each year: _____
Union Employment: _____
Fringe benefits received: _____
(health insurance, pension, paid vacations, other)
Nature of work performed: _____

If personal Injury:
Has the subject returned to work since the accident? _____ Date Returned: _____
Has the subject returned to work with less equal or more hours than prior to injury? _____
Has subject began to prepare for retirement? _____
At what age does/did the subject expect to retire? _____

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EMPLOYER II

Company Name: _____ Job Title: _____
From: _____ To: _____
Work Address: _____ City: _____ State: ___ Zip: _____
Employment Contact: _____ Telephone #: _____ Fax #: _____
Address: _____
Wage Rate: _____ Pay Period: _____
(annual, monthly, weekly, hourly*)

*If hourly, how many hours normally worked? _____ How many hours overtime: _____
Overtime rate: _____ Number of months at work during each year: _____
Nature of the work performed: _____
Fringe benefits received: _____
(health insurance, pension, paid vacations, other)

EMPLOYER III

Company Name: _____ Job Title: _____
From: _____ To: _____
Work Address: _____ City: _____ State: _____ Zip: _____
Employment Contact: _____ Telephone #: _____ Fax #: _____
Address: _____
Wage Rate: _____ Pay Period: _____
(annual, monthly, weekly, hourly*)

*If hourly, how many hours normally worked? _____ How many hours overtime: _____
Overtime rate: _____ Number of months at work during each year: _____
Nature of the work performed: _____
Fringe benefits received: _____
(health insurance, pension, paid vacations, other)

EMPLOYER IV

Company Name: _____ Job Title: _____
From: _____ To: _____
Work Address: _____ City: _____ State: _____ Zip: _____
Employment Contact: _____ Telephone #: _____ Fax #: _____
Address: _____
Wage Rate: _____ Pay Period: _____
(annual, monthly, weekly, hourly*)

*If hourly, how many hours normally worked? _____ How many hours overtime: _____
Overtime rate: _____ Number of months at work during each year: _____
Nature of the work performed: _____
Fringe benefits received: _____
(health insurance, pension, paid vacations, other)

SPOUSE'S INFORMATION REQUEST

(if applicable)

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INSTRUCTIONS

Complete the following line items. Please attach additional pages as necessary.

Spouse's Name: _____ Gender: _____ Race: _____
DOB: _____ Occupation: _____
Place of Residence: _____

Educational Attainment: (indicate grade level last completed) _____
Year Completed: _____

SPOUSE'S GENERAL HEALTH

Smoker? _____ Amount per day: _____
Year spouse quit smoking: _____
Does the spouse have a history of heart disease? _____ Date of Diagnosis: _____
Date of last episode: _____ Are medications taken? _____
Does spouse have a history of Diabetes? _____ Date of Diagnosis: _____
Type of Diabetes: _____ Controlled by: _____
Pre-existing chronic health conditions:
Please indicate any of the spouse's disabilities, illnesses, dependencies, etc. that may be relevant to the case.

_____

EMPLOYER I

(If necessary, include a separate sheet detailing spouses's work history)

Company Name: _____ Job Title: _____
From: _____ To: _____
Work Address: _____ City: _____ State: _____ Zip: _____
Employment Contact: _____ Telephone #: _____ Fax #: _____
Address: _____
Wage Rate: _____ Pay Period: _____
(annual, monthly, weekly, hourly*)

*If hourly, how many hours normally worked? _____ How many hours overtime: _____
Overtime Rate: _____ Number of months at work during each year: _____
Union Employment: _____
Fringe benefits received: _____
(health insurance, pension, paid vacations, other)
Nature of work performed: _____

If personal Injury:
Has spouse experienced diminished earnings due to accident? _____
If Yes, explain: _____

_____

_____

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OTHER EXPERTS WORKING ON THIS CASE

Indicate the name, address, and telephone number of other expert witnesses working on this case that may need to be contacted or whose opinion may assist in our analysis. Use additional sheets as necessary.

_____

_____

_____

ADDITIONAL INFORMATION

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

- [x] Copy of Complaint
- [x] Deposition of Plaintiff - if any
- [x] Deposition of Expert(s) – Including Plaintiffs Doctors and Life Care Plan (if any)
- [ ] Report of Medical Expert(s)
- [x] Report of Vocational Rehabilitation Expert(s) including Plaintiffs Vocational/Life Care Plan Report *(For Personal Injury Cases Only) – if available*
- [x] Copy of relevant responses to interrogatories
- [x] 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
- [x] 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)
- [x] Other
  - [x] Social security earnings history (http://www.eprlegaleconomics.com/assets/Uploads/
  - [x] Answers to interrogatories Social-Security-Request-Form-2011.pdf)

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INSTRUCTIONS

Carefully complete the following items. Please attach additional pages as necessary.

Child's Name: _____ Gender: _____ Race: _____
DOB: _____ Occupation: _____
Place of Residence: _____
Educational Attainment: (indicate grade level last completed) _____ Year Completed: _____
Marital Status: NA Spouse Name: NA
Date of Marriage: NA Spouse DOB: NA
If wrongful death, date of death: (if different from date of accident) NA

SURVIVING DEPENDENTS

Name:	DOB:	Relationship:	Dependent:	Living in Household:
NA				

HOUSEHOLD STATUS

Did the child maintain a houshold prior to the accident? _____
If a personal injury, does the child currently maintain a household? _____
Has the injury changed the manner in which the household is maintained? _____
Does the injury currently affect the child's ability to maintain the household? _____

CHILD'S GENERAL HEALTH

Smoker/Non-Smoker: _____ Amount per day: _____
Year child quit smoking: _____
Does the child have a history of heart disease? _____ Date of Diagnosis: _____
Date of Last episode: _____ Are medications taken? _____
Does the child have a history of Diabetes? _____ Date of Diagnosis: _____
Type of Diabetes: _____ Controlled by: _____
Preexisting chronic health conditions:
Please indicate any of the child's disabilities, illnesses, dependencies, etc. that may be relevant to the case.

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Date of Marriage: NA Spouse DOB: NA
If wrongful death, date of death: (if different from date of accident) NA

SURVIVING DEPENDENTS

Name:	DOB:	Relationship:	Dependent:	Living in Household:
NA				

HOUSEHOLD STATUS

Did the child maintain a houshold prior to the accident? _____
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