Hankins & Hankins

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Norman E. Hankins, Ed.D.
~~ May 15, 1935 – February 11, 2018 ~~

EVALUEE INFORMATION FORM

Please complete all relevant sections of this form. Do not hesitate to contact our office if you have any questions about the requested information.

TYPE OF CASE:

_____ Social Security Disability
_____ Personal Injury
_____ Long-Term Disability
_____ Marital Dissolution
_____ FELA
_____ Workers' Compensation
_____ Wrongful Death
_____ Medical Malpractice
_____ Wrongful Termination
_____ Other (please specify) _____

REFERRAL SOURCE INFORMATION:

Referral Source: _____
Counsel for: _____ PLAINTIFF _____ DEFENSE
Name of Firm: _____
Address: _____
_____
Telephone: _____ Facsimile: _____
E-Mail: _____

DATE/TIME OF APPOINTMENT:

_____

CASE INFORMATION:

Court-imposed deadline date (if any): _____
Case Citation: _____
Court/Location: _____
Judge: _____ Opposing Attorney: _____
Trial/Hearing Date(s): _____
Expected Testimony Date(s): _____

EVALUEE INFORMATION:

Name: _____

Address: _____

_____

Telephone: _____ Social Security Number: _____

Date of Birth: _____

Date of Injury (if applicable): _____

Date of Death (if applicable): _____

Educational Attainment:

_____ Less than High School Highest Grade Completed: _____

_____ GED

_____ High School Diploma

_____ Vocational School Trade: _____

_____ Some College (no degree) Major: _____

_____ Associate Degree Degree: _____

_____ Bachelor's Degree Degree: _____

_____ Master's Degree Degree: _____

_____ Doctorate Degree Degree: _____

Employer at time of incident: _____

Occupation at time of incident: _____

Pay Rate at time of incident (e.g. hourly or weekly wage/salary): _____

Hours Worked Per Week at time of incident: _____

Work History (do not include jobs lasting less than 3 months):

Employer/Occupation: _____ Years Worked: _____

Employer/Occupation: _____ Years Worked: _____

Employer/Occupation: _____ Years Worked: _____

Employer/Occupation: _____ Years Worked: _____

Employer/Occupation: _____ Years Worked: _____

Employer/Occupation: _____ Years Worked: _____

Employer/Occupation: _____ Years Worked: _____

Employer/Occupation: _____ Years Worked: _____

Employer/Occupation: _____ Years Worked: _____

Employer/Occupation: _____ Years Worked: _____

* If a Social Security disability case, only include work performed in the past 15 years.

Please take care in completing this form as this foundation information is important to our analysis and will become a part of our case file. Additionally, leave blank any portion of this form that is inapplicable or for which information is not available.