Countermeasures Investigations / Surveillance
PO Box 290127
Wethersfield, CT 06129
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File Date ___________________
Date of Loss: __________________
Your File #__________________________
Completion Date:__________________________

Subject:____Date of Birth:________________

Social Security #_________________________________Marital Status:_____________________

Address:____

Telephone Number (Home):_______________________ (Work/Cell) ______________________

Physical Description: (_) Male (_) Female
(_) White (_) Black (_) Hispanic (_) Other

Height:____________ Weight:___________Hair Color __________ Glasses: (_) Yes (_) No

Distinguishing
Characteristics:____

Type of Injury:____

Physical Restrictions:____

Employment:_________________Address_____________________Occupation______________

Known Vehicles (1):_____________________________Hobbies______________________________

Claimant's Doctor_________________________Address_____________________________________

Next Appointment (Date/Tiime)______________________Attorney Represented: (__)Yes (__) No

Instructions for Surveillance____

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Client Contact Information

Name______________________Phone Number_______________Email:_____________________

Hours Allocated___________________Surveillance ever conducted before?: (__)Yes (__) No

Notes:____

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