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Totally
 Confidential
 Investigations, Inc.
Investigation Request Form

Client Information

Company		Requestor		Phone	
Address		City	State	Zip Code	
E-mail			Fax		
Assignment Date		# of Days	Video Format <input type="checkbox"/> VHS <input type="checkbox"/> DVD <input type="checkbox"/> Client Login		
			Reports <input type="checkbox"/> Client Login <input type="checkbox"/> Mail <input type="checkbox"/> E-mail		
Assignment Category: <input type="checkbox"/> Surveillance <input type="checkbox"/> Background <input type="checkbox"/> Interviews <input type="checkbox"/> Activity Check <input type="checkbox"/> Other _____					

Employer Information

Employer		Insured Contact:		May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address		City	State	Zip Code	
Phone 1	Phone 2		E-mail		

Claimant Information

Claim #		Type of Claim			
Claimant's Full Name				SS #	
Physical Address		City	State	Zip	
Home Phone		Mobile Phone		Other	
Confidential Contact for description				Contact #	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	DOB	Race	Height	Weight	Hair Color
Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No		Other Characteristics (facial hair-markings etc)			
Marital Status <input type="checkbox"/> Sing <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid		Children <input type="checkbox"/> Yes <input type="checkbox"/> No	# of Children	Ages	
Known Vehicle Info		Receiving Benefits <input type="checkbox"/> Yes <input type="checkbox"/> No		Where	

Injury Information

Injury Date		Injury Description			
Scheduled Appointments <input type="checkbox"/> Yes <input type="checkbox"/> No		Date	Physician		
Represented by Attorney <input type="checkbox"/> Yes <input type="checkbox"/> No		Attorney Name			
Previous Surveillance Conducted <input type="checkbox"/> Y <input type="checkbox"/> N		Dates/Location			
Previous Surveillance Reports					
Special Instructions					