

WAGE LOSS

PERSONAL INJURY VALUATION FORM

ATTORNEY INFORMATION:

Attorney Name: _____ Date: ____/____/____

Firm: _____

Street: _____

City, State, Zip: _____

Telephone: (____) _____ Facsimile: (____) _____

Email: _____

Case Name: _____

CASE INFORMATION:

Subject's Name: _____

Race (for actuarial purposes only): _____ Gender: M F

Date of Birth: ____/____/____ Date of Injury: ____/____/____

PRE-INJURY EARNINGS HISTORY:

Job Title: _____

Job Description: _____

Employer: _____

Last Five Years of Income: (Data from W-2s, 1099s, pay stubs, etc.)	Year	Annual Income	# of Months Worked	Employer Paid Fringe Benefits
_____	_____	\$ _____	_____ months	<input type="checkbox"/> Medical
_____	_____	\$ _____	_____ months	<input type="checkbox"/> Dental
_____	_____	\$ _____	_____ months	<input type="checkbox"/> Pension
_____	_____	\$ _____	_____ months	<input type="checkbox"/> Other
_____	_____	\$ _____	_____ months	

Please list additional information (job changes, career plans, promotions, etc.) on a separate sheet.

All fees and rates are subject to change without notice.

Robert W. Johnson & Associates

4984 El Camino Real • Suite 210 • Los Altos, CA 94022
650/494-2413 • 800/541-7435 • FAX 650/494-2454

Website: www.rwja.com • Email: info@rwja.com

POST-INJURY EARNINGS AND MEDICAL EXPENSES:

SUBJECT'S NAME: _____

Job Title: _____

Job Description: _____

Employer: _____

Full-time: _____ hours per week Part-time: _____ hours per week

Last Five Years of Income:	Year	Annual Income	# of Months Worked	Employer Paid Fringe Benefits
(Data from W-2s, 1099s, pay stubs, etc.)	_____	\$ _____	_____ months	<input type="checkbox"/> Medical
	_____	\$ _____	_____ months	<input type="checkbox"/> Dental
	_____	\$ _____	_____ months	<input type="checkbox"/> Pension
	_____	\$ _____	_____ months	<input type="checkbox"/> Other
	_____	\$ _____	_____ months	

Please list additional information (job changes, career plans, promotions, etc.) on a separate sheet.

Estimated Future Medical Expenses: **Medical Expenses to Date:** \$ _____

Date	Expense	Description
____/____/____	\$ _____	_____
____/____/____	\$ _____	_____

Include additional relevant information on a separate sheet.

PAYMENT:

Plaintiff Defense Evaluation needed by: ____/____/____

Minimum retainer for \$2,500 (includes \$1,050 non-refundable) payable to Robert W. Johnson & Associates. If additional work is required, it will be invoiced at current hourly rates and will be due and payable upon receipt. Payment of all balances is due prior to releasing opinions and/or reports. \$ _____

Case Set-Up Fee (Non-Refundable) \$ 500.00

Additional Original Bound Reports: _____ copies @ \$50.00 each..... \$ _____

Check **Total:** \$

Please charge my MC AMEX VISA Card # _____

Name as printed on card: _____ Expires: ____/____/____

Zip code of credit card billing address: _____

Signature: _____ Date: ____/____/____

AGREEMENT:

The undersigned hereby engages Robert W. Johnson & Associates with respect to the above named case and on the terms and conditions stated above. This contract is made in Los Altos, California on the day and year written below. Should litigation be needed to collect any charges pertaining to this case, Robert W. Johnson & Associates shall be entitled to attorney's fees and all costs of collection in addition to principal and finance charges.

Retaining Attorney's Signature: _____ **Date:** ____/____/____

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PERSONAL INJURY WAGE LOSS
SUPPLEMENTAL INFORMATION NEEDED

- Brief synopsis of case or copy of complaint.
- Income for past 3 to 5 years (W2's, 1099's, Schedule C's, etc).
- Plaintiff's fringe benefits and the cost of the benefits paid by the employer on behalf of the employee. We are looking for the employer's contribution. Fringe benefits can consist of: medical, dental, vision, life, 401k matching portion, pension, auto allowance, etc.