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CONSULTING ECONOMIST

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CHECKLIST FOR ECONOMIC EVALUATION -- PERSONAL INJURY®

Please	return completed form.				
Date:	/				
Teleph	one Contact: Attorney / Paralegal			_	
	or Family Representative:				
Report	t due date:/				
1.	Name of Injured:				
	A. Male Female B. White Black				
	Type of Injury:				
	Does the injured have a terminal disease?				
	If yes, enter projected death date/_ Limited declared by DOCTOR:/	/			
	Ellinica acciaica by DOCTOR.	/0			
2.	A. Client Birth Date	/	_		
	B. Client Injury/Accident Date	/	_		
	C. Client Mediation/Arbitration Date	//	_		
	D. Client Trial Date	/	- (II)		(0)
	E. Client Phone #(s)		(H)		(C)
3.	Spouse:	Male / Female	Date of Birth	/ /	/
	Children:	Male / Female	Date of Birth		/
	Children:	Male / Female	Date of Birth	//	/
	Children:	Male / Female	Date of Birth	//	
	Other Dependents:	Male / Female	Date of Birth	//	<u> </u>
4.	A. Educational Attainment (years comple	eted)			
	Elementary High School 2Y	<u> </u>			
	B. Diploma, Certificate and/or Degrees C	Completed:			
5.	A. Job Title at Accident/Injury				
<i>J</i> .	B. Employer's Name at Injury Date				
	C. Nature of Work (Briefly Describe)				
	D. Opportunity for Advancement/Promot				
	(Normal) (Special-Expla				
	E. Self-Employed? (YES) (NO)				
	F. Returned to work? (YES) (NO) If yes enter date:/				
	G. Company Retirement Age				
6.	Earning History and Records:				
	Please provide earnings records for five	40, wage s	statements-W2's.		
	A. Pre-Accident/Injury Employer Annual Earnings Dates (Fro				
	B. Post-Accident/Injury				
	Employer Annual Earnings Dates (Fro				
	C. If working today in pre-accident/injury				
	Provide current rate of pay		_		
	D. If union contract employee, please sup	oply copies of contracts pro	e and post injury/accid	lent.	

7.	Fringe Benefits					
	Specify amount in dollars paid by employer (annually) on behalf of injured employee:					
		Pre-Injury/Accident	Post (if any)			
	1. Group Health/Hospitalization Insurance	\$	\$			
	2. Life Insurance	\$	\$			
	3. Retirement Plan (401K, IRA, or other)	\$	\$			
	4. Stock Options	\$	\$			
	5. Social Security	\$	\$			
	6. Workman's Compensation	\$	\$			
	7. Vacation	\$	\$			
	8. Sick Pay	\$	\$			
	9. Other (explain)	\$	\$			
8.	Household Services: Kindly specify number of hours per (week):					
		Pre-Injury/Accident	Post			
	1. Cleaning	hrs.	hrs.			
	2. Laundry	hrs.	hrs.			
	3. Cooking	hrs.	hrs.			
	4. Shopping	hrs.	hrs.			
	5. Auto Maintenance	hrs.	hrs.			
	6. Painting/Decorating	hrs.	hrs.			
	7. Household Repairs	hrs.	hrs.			
	8. Family Bookkeeping	hrs.	hrs.			
	9. Babysitting	hrs.	hrs.			
	10. Driving Services	 _	hrs.			
	11. Lawn/Yard Care	hrs.				
		hrs.	hrs.			
	12. Other - ADL's (specify)	hrs.	hrs.			
9.	Future Medical Maintenance Expenses					
	(Please attach Life Care Plan or Continuation of Care Plan if available - and/or - complete below)					
		Type of Care Dollars / Year				
	A. Physician Services	\$				
	B. Medications/Over-the-Counter Drugs	\$				
	C. Equipment and Supplies	\$				
	D. Hospitalizations	\$				
	E. Surgeries (Please specify)	\$				
	F. Other	\$				
10.	If injured was not employed or a minor, please and/or work experience of parents (years of sch		nation regarding education			
11.	Other Considerations: Please include any of the following records if possible.					
	1. Interrogatories					
	2. Deposition transcripts of parties					
	3. Fringe benefit booklets					
	4. Retirement booklets					
	5. Other relevant documents as needed/specified					
	6. Savings / Assets – Ex: Mortgage Information of Property Owned, Money market Accounts, Interest Bearing					
	Checking and/or Savings Accounts, etc.	. of 1.10perty of mice, money marke	Transfer bearing			