

Federal Workers Compensation Consultants, Inc.
Social Security Disability Representatives
9639 North Armenia Ave., Tampa, Fl. 33612

CONTRACT OF REPRESENTATION, POWER OF ATTORNEY, & TRUST AGREEMENT

CLAIMANT: _____
EMPLOYER: _____
SOC. SEC. NO: _____ DOI: _____
TYPE OF ACTION: _____ (*WORKERS COMP. OR SS DISABILITY*)

I, the undersigned Employee/Claimant, pursuant to the applicable C.F.R. hereby retains, selects and employs Federal Workers Compensation Consultants, Inc.(FWCC), 9639 North Armenia Ave., Tampa, Florida 33612, as my designated representative to represent me in the administrative arena with respect to the industrial accident and injury or other claims in regard to my employment claims I may have, under the following terms and conditions:

1). **AUTHORIZATION.** I authorize FWCC to act on my behalf in prosecution my employment claims with the Federal government and I further authorize it to make such investigations, undertake such legal proceedings and to expend such monies on my behalf as FWCC deems necessary. I recognize that the principals of FWCC are not Attorneys and I am retaining them as my Consultant/Advocate to act in that capacity and not to render any legal advice.

2). **CONSULTATION/RESEARCH/INVESTIGATIVE FEES.** I agree to pay to FWCC a reasonable fee for services rendered with respect to my Federal employment matters. I am depositing with FWCC \$100.00 as a deposit for costs and as a non-refundable consultation and fee retainer. I agree to pay to FWCC a monthly fee of \$125.00 for the costs and time expended in handling of my case/claim. If I have more than one OWCP claim there will be an additional charge of \$25.00 for each additional case including handling disability retirement. Payment of the aforementioned fee will begin on (*circle one*) 1st of the month or 15th of the month and continue monthly thereafter until the resolution of my case or I decide that I want to terminate the contract. Termination will be considered in affect, 5 working days after the post mark date, on the envelope it is sent in. No interest will be charged on balances if the minimum payment is made. If the minimum payment is not made, interest on the balance will be assessed at 10 % per month. If formal collection efforts become necessary FWCC will be entitled to reimbursement for filing fees, service fees, other Court costs, collection agency costs, and/or attorney's fees in connection with the action to collect the debt.

3). **TOTAL FEES AND COSTS** The total fees and costs incurred by me will be ten percent (10%) of the schedule of awards and/or any back pays ultimately paid to me. Money remitted pursuant to paragraph 2 above will be credited towards the total fees and costs calculated using the 10% factor. If the client has more than one claim, the client must designate which claim is credited with the \$100.00 (for the deductible) and which claim is credited with the \$25.00 (for the deductible). If I am unsuccessful in obtaining an award, the fees paid as set out in paragraph 2 above will be the total amount charged by FWCC and I will owe nothing further. FWCC may associate a law office as it

deems fit to pursue my benefits at no additional cost to FWCC other than the aforesaid rate of FWCC. I will retain the option of selecting the attorney to pursue my claim or I may elect to allow FWCC to select the firm. I understand that I will be obligated to the attorney for his/her time in pursuing the claim. In regard to OWCP matters, I understand that if I do not agree with the amount of fee charged, I have a right to dispute the same and that the Secretary of Labor then must approve the amount of the fee charged.

4). **COSTS.** I agree to reimburse FWCC for all costs associated with the prosecution of my claim to the extent these costs are reasonable, regardless of the outcome of my claim. In the event that my case involves some extraordinary cost expenditures, I may be required to pay to FWCC an additional cost deposit. The reasons for the additional cost deposit will be explained to me and the final decision on whether or not to expend the additional monies will be mine. Any money held in trust or otherwise under this contract may be used to pay costs incurred on my behalf. The costs include, but are not limited to the following:

1. Postage
2. Reasonable copying charges (10 cents per page)
3. Office supplies
4. Witness fees if necessary
5. Reasonable travel and lodging costs if necessary

5). **CLIENT'S RESPONSIBILITIES.** I agree to promptly and fully advise FWCC as to any developments or information which may have a bearing on my worker's compensation claim and to keep FWCC advised at all times as to my whereabouts and my correct mailing address.

I will promptly attend any appointments made for me by FWCC and to submit to any medical or vocational examinations or evaluations arranged by FWCC or their associated attorney.

I will not discuss my case with any person not specifically authorized by FWCC.

I agree to cooperate fully with FWCC.

I understand that my representative expressly relies on the truthfulness of all statements made by me and that I may be subject to criminal prosecution if I make false or misleading statements in connection with my worker's compensation claim.

I UNDERSTAND THAT MY REPRESENTATIVE MAY TERMINATE THIS CONTRACT OF REPRESENTATION IF I DO NOT FULLY COMPLY WITH THIS AGREEMENT. IF I FALL 60 DAYS BEHIND IN MY PAYMENTS, MY CASE WILL BE PLACED IN THE INACTIVE FILES AND IF I DO NOT MAKE PAYMENTS BY THE 90TH DAY, THE FILE WILL BE CLOSED. FWCC WILL RETAIN MY FILE FOR ONE YEAR FOR ME TO PICK IT UP. IF I DO NOT PICK UP THE FILE IN THE ONE YEAR PERIOD, THE FILE WILL BE DESTROYED. I MAY TERMINATE THIS AGREEMENT AT ANY

TIME BY PROVIDING WRITTEN NOTICE TO FWCC. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYMENT OF ALL FEES EARNED AND COSTS EXPENDED UNTIL THE DATE OF TERMINATION OF THE AGREEMENT.

6). **REPRESENTATIVES RESPONSIBILITIES**. FWCC agrees to diligently pursue my employment claims and to keep me fully informed as to my claim status. FWCC accepts the trust provisions of this agreement and will account to me as to any monies received, expended or held on my behalf at my request.

7). **REPRESENTATIONS**. The parties freely enter into this representative agreement and no promises or representations, other than those provisions cited herein and reduced to writing are made or implied.

This Contract is freely entered into this _____ day of _____, 200__.

Employee/Claimant

FWCC representative for Employee/claimant

Printed Name of Employee/Claimant

Printed Name of Representative/ Position

SSN of Employee/Claimant

Dated: _____

Dated: _____

**AUTHORIZATION FOR RELEASE OF
MEDICAL AND WAGE INFORMATION**

TO WHOM IT MAY CONCERN:

This authorizes the physicians, hospitals, medical attendants, employers, record custodians, governmental bodies, their agencies and all other persons, firms and corporations to furnish full and complete medical reports, records and any and all other information, or copy thereof, about and concerning the undersigned (*print your name*) _____ to Federal Workers Compensation Consultants, Inc. of 9639 North Armenia Ave., Tampa, Florida 33612 or to any representative, attorney or investigator from that firm. You are requested to cooperate with the firm and furnish to the firm such information deemed necessary by it to represent me properly.

ALL PRIOR OR INCONSISTENT AUTHORIZATIONS ARE HEREBY CANCELED. This authorization is valid until canceled in writing. You are authorized to accept a copy of this authorization in lieu of the original.

Dated: _____

Employee/Claimant

Date of Birth: _____

Soc. Sec. No.: _____

**Federal Workers Compensation Consultants, Inc.
9639 North Armenia Avenue
Tampa, Florida 33612-7552**

**Workers' Compensation
Consultants**

**Phone: (813-931-1984)
(813-933-2667)
Fax: (813-931-4905)**

To Whom It May Concern:

I hereby authorize Federal Workers Compensation Consultants to represent me in my claim for Workers Compensation, the Employee Compensation Appeals Board (ECAB), the Oral Hearing, any Reviews Board and any appeals for Reconsideration.

Sign Name

Date

Print Name

Date

File Number

Social Security Number

INTAKE SHEET

EEO YES _____
NO _____

OWCP YES _____
NO _____

CASE NO. _____

PRINT NAME

ADDRESS (number, street, apt.)

CITY, STATE, ZIP CODE

HOME PHONE NUMBER

WHO IS YOUR EMPLOYER

EMPLOYER'S STREET ADDRESS, CITY STATE ZIP CODE

WORK PHONE NUMBER

SOCIAL SECURITY NUMBER

DATE OF BIRTH

DATE OF INJURY

BILLING DATE _____ 1ST OF THE MONTH _____ 15TH OF THE MONTH
CHECK ONE

It is your responsibility to keep Federal Workers Compensation Consultants, up to date in any changes to the information referenced above.

SIGNED

DATE