Date: [Insert Date]

TO: [Investigator Name/Agency]
FROM: [Your Name/Company Name]
RE: Surveillance Instructions - Workers Compensation Claim

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1. SUBJECT INFORMATION

Name: [Claimant Full Name]
Address: [Full Residential Address]
DOB: [Date of Birth]
Physical Description: [Height, Weight, Hair Color, Identifying Marks]
Vehicle Info: [Make, Model, Color, License Plate Number]

2. CLAIM DETAILS

Date of Injury: [Date]
Alleged Injuries: [List specific body parts and limitations]
Current Work Status: [e.g., Total Disability / Light Duty]
Subject's Typical Schedule: [List known appointments or routine]

3. SCOPE OF WORK

Objective: To document the claimant's physical activities and determine if they are consistent with their reported medical restrictions.

Assigned Hours: [Total number of hours, e.g., 24 hours over 3 days]
Specific Dates: [Insert Dates]

4. SPECIAL INSTRUCTIONS

- Focus on [e.g., lifting, bending, driving, yard work].
- Identify any secondary employment or physical labor.
- Obtain clear video footage of the subject's face for identification.
- Conduct a neighborhood canvass if no activity is observed at the residence.

5. REPORTING AND DELIVERABLES

- Provide a written daily activity log via email.
- A final investigative report including all time logs and findings.
- High-definition video files with date and time stamps.
- Immediate notification if the subject is observed engaging in strenuous activity.

6. COMPLIANCE

All surveillance must be conducted within the bounds of local and state laws. Investigators must not trespass on private property or engage in any form of harassment.

Authorized Signature: _____