STEVEN S. ISONO, M.D.

1 CAMINO SOBRATE, SUITE 217, ORINDA, CA 94563

**DEPOSITION REQUEST**

[ ]  CIVIL [ ]  WORKER’S COMP

DATE:

PATIENT’S NAME:

PATIENT’S BIRTHDATE:

REQUESTING ATTORNEY:

DEFENSE / APPLICANT / INSURANCE CARRIER (PLEASE CIRCLE ONE)

CONTACT PERSON:

PHONE NUMBER AND EXTENSION:

FAX NUMBER:

**PLEASE FAX REQUEST TO (844)270-2011.**

**WE WILL FAX THREE AVAILABLE DATES FOR YOU TO CHOOSE FROM.**

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL (510) 844-4545**