30 Chestnut Street
Quincy, MA 02169
617-471-3510

# DEPOSITION REQUEST SHEET

Name: ______________________________________________________________

Address: ________________________________________________________

City/State/Zip: ___________________________________________________

Telephone: ____________________________ Fax: ________________________________

Email: ______________________________________________________________

DEPOSITION INFORMATION:

Deposition Date: ______________________________________________________

Deposition Time: _______________________________________________________

Deposition Location: ___________________________________________________

Case Name: ________________________________________________

Case Number: _________________________________________________________

Deponent Name: ________________________________________________________

Expected Length of Deposition: ____________________________________________

Requested Delivery Date: _____________________________________________

Examination Under Oath: Y / N

Expert Witness: Y / N If yes, please specify_________________________________

Number of Copies: ______________________

Mini With Indexing: Y / N

Emailed PDF: Y / N

## CONFIRMATION

Reporter: Day Requested __________ 24hrs Prior to Depo ______________

Client: Day Requested____________ 24-hrs Prior to Depo____________