SAVE PRINT CLEAR

# REQUEST FOR CONSULTATIVE RATING

State of California
Division of Workers' Compensation
Disability Evaluation Unit

DEU Use Only

Indicate type of request: ❑ Mail-in ❑ Walk-in

**INSTRUCTIONS FOR MAIL-IN'S:**

1. Enclose pre-addressed envelopes for yourself and the opposing party.
2. Attach a photocopy of the medical report(s) for which a rating is being requested. Do not send original reports.
3. Send this request to the DEU office serving the WCAB location in which the case has been filed.
4. Serve a copy of this request on the representative for the opposing party.

**INSTRUCTIONS FOR WALK-IN'S:**

1. Place report(s) to be rated on top of the WCAB file, unless report has been placed into evidence.
2. If report(s) have been placed into evidence, clearly mark them with a paper clip or post-it note.
3. If a deposition is to be rated, mark or list the pages to be reviewed by the rater.

| | |
|---|---|
| Injured worker's name | |
| WCAB case number(s) | |
| Occupation (attach description if unclear) | |
| Date of injury | |
| Date of birth | |
| Social security number | |

Date of report(s) to be rated and doctor's name:

____/____/____ _____

____/____/____ _____

____/____/____ _____

This case has been set for: ❑ hearing ❑ msc on ____/____/____.
❑ conference ❑ rating pre-trial

Rating requested by: _____ representing the ❑ employee
*name of firm* ❑ employer

A copy of this request has been served on _____.
*name of firm*