

STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT
MAILING ADDRESS:
P. O. Box 71010
Oakland, CA 94612
(510) 286-3700 or (800) 794-6900 Fax: (510) 622-3467

QME APPOINTMENT NOTIFICATION FORM

To the Qualified Medical Evaluator: You are required by law to give notice on this form when an appointment has been made with you to perform a QME comprehensive medical evaluation. Please complete this form in its entirety. You are legally required to include: the name and address of the employee, the name of the employer and claims administrator, and the appointment time and date. The Administrative Director also requires that you serve this appointment notification form on the employee and the claims administrator or, if none, the employer, or their attorneys in a represented case, within five (5) business days after having scheduled the injured worker to be seen for a QME comprehensive medical evaluation.

EMPLOYEE INFORMATION

NAME: _____
ADDRESS: _____
City State Zip
PHONE: _____ SOCIAL SECURITY No. _____
(Social Security Number is for record-keeping purposes only.)
DATE OF INJURY: _____ PANEL No.: _____ CLAIM/CASE No.: _____

EMPLOYER INFORMATION

NAME: _____
ADDRESS: _____
City State Zip
PHONE: _____

INSURER or CLAIMS ADMINISTRATOR INFORMATION

NAME: _____
COMPANY: _____
ADDRESS: _____
City State Zip
PHONE: _____

APPOINTMENT INFORMATION

DATE OF APPOINTMENT CALL _____ DATE OF APPOINTMENT _____ TIME OF APPOINTMENT _____
LOCATION OF APPOINTMENT: _____
CERTIFIED INTERPRETER REQUIRED: (LANGUAGE) _____

COPY TO: EMPLOYEE (or employee's attorney, if known)
 CLAIMS ADMINISTRATOR/EMPLOYER (or attorney, if known)

SIGNATURE OF QME: _____
QME NAME (print/type) _____
ADDRESS AND PHONE _____

Note to Claims Administrator: The Administrative Director's regulation 10160 requires you to forward a completed DEU Form 101, "Request for Summary Rating," together with all medical reports and medical records prior to the scheduled examination with the QME. You must also provide the employee with a DEU Form 100, "Employee's Disability Questionnaire," prior to the examination.