PRINT CLEAR

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
MEDICAL UNIT
MAILING ADDRESS:
P. O. Box 71010
Oakland, CA 946123
(510) 286-3700 or (800) 794-6900 Fax: (510) 622-3467

VOLUNTARY DIRECTIVE FOR ALTERNATE SERVICE OF MEDICAL-LEGAL EVALUATION REPORT ON DISPUTED INJURY TO PSYCHE
(Unrepresented Employees Only)

Injured Employee Name: _____

Date of Injury: _____

Claim No.: _____

EAMS or WCAB Case No.: _____

Claims Administrator: _____

Name of QME: _____

Date of Evaluation Exam: _____

I, _____**,**
(print name of injured employee)

understand I have a right to be served with a copy of the medical-legal evaluation report written about my case by the QME physician named above, at the same time as a copy of the report is sent to the claims administrator and/or the Disability Evaluation Unit.

By signing below, I hereby direct that the QME serve my copy of the medical/legal report in the following manner:

(Check one)

☐ **By sending my copy to the following physician who will review it with me and will be paid for an office visit for this purpose by the claims administrator, or if none by my employer. The physician I name below may be my primary treating physician in this case or any other physician I wish to designate. At the end of that visit, the physician named below will give me my copy of the report:**

Physician Name: _____

Address: _____

City: _____ **State:**_____ **Zip:**_____

Phone: _____

☐ **Only by sending a copy to me at my address on file. I do not wish to designate a physician to review it with me.**

I am signing this directive voluntarily and of my own free will:

_____ _____
(Signature of Injured Employee) ***Date***

Original of this signed form – attach to original medical-legal report
Copies of this signed form – to injured employee, claims administrator, reviewing physician, QME