State of California
Division of Workers' Compensation-Medical Unit
QME Appointment Notification Form

Print Form

Reset Form

Please complete this form in its entirety. *The Administrative Director requires that you serve this appointment notification form on the employee and the claims administrator, or, if none the employer, and their attorneys in a represented case, if known, within five (5) business days after having scheduled the injured worker to be seen for a QME comprehensive medical evaluation. You may not cancel the appointment less than six (6) calendar days prior to the appointment date, except for good cause (See, 8 Cal. Code Regs. §34). If you reschedule an appointment, review regulation 34 and the ethical rules in regulation 41 (See, 8 Cal Code Regs. §§ 34, 41(a) (7) and (a) (8)).*

Employee Information *(Completion of this section is required)*

Employee Name _____ Phone Number _____

Employee Street Address _____ Employee City _____ State _____ Zip Code _____

Date of Injury _____ Panel Number _____ Claim or Case Number _____

Employer Information

Employer Name _____

Employer Street Address _____ Employer City _____ State _____ Zip Code _____

Claims Administrator Information *(Completion of this section is required)*

Claims Administrator Name (Insert the name of the person handling the claim) _____ Phone Number _____

Claims Administrator Company (Insert the name of the company handling the claim) _____

Claims Administrator Street Address _____ Claims Administrator City _____ State _____ Zip Code _____

Appointment Information *(Completion of this section is required)*

Date of appointment call: _____ Date of Appointment: _____ Time of appointment: _____

Examination address _____ Examination City: _____ Zip Code _____

Records should be sent to the following address: _____ Street address or P.O. Box _____ City: _____ Zip Code _____

Is a certified interpreter required? Yes ☐ No ☐ If an interpreter is required, indicate language: _____

QME Name: _____

QME Street Address _____ QME City _____ State _____ Zip Code _____

Date Signed: _____ Signature of the QME: _____

Note to Claims Administrator: The Administrative Director's regulation 10160 requires you to forward a completed, DWC-AD form 101(DEU) (Request for Summary Rating Determination of Qualified Medical Evaluator's Report) (see, 8 Cal. Code Regs. §§ 10160 and 10161) together with all medical reports and medical records prior to the scheduled examination with the QME. You must also provide the employee with a DWC-AD form 100 (DEU) (Employee's Disability Questionnaire)(See, 8 Cal. Code Regs. §§ 10160 and 10161) prior to the examination.

Declaration of Service

I declare that I am a resident of or employed in the county where the mailing took place. I am over the age of eighteen years and I am not a party to this case, my business or residence address is:

On _____ , I served this Additional Panel Request form, the original, or a true and correct copy of the original, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

A depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.

B placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.

C placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.

D placing the sealed envelope for pick up by a professional messenger service for service *(Messenger must return to you a completed declaration of personal service.)*

E personally delivering the sealed envelope to the person or firm named below at the address show below.

Method of Service _____ Person or firm served _____ Street Address _____
City _____ State _____ Zip Code _____

Method of Service _____ Person or firm served _____ Street Address _____
City _____ State _____ Zip Code _____

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City _____ State _____ Zip Code _____

Method of Service _____ Person or firm served _____ Street Address _____
City _____ State _____ Zip Code: _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: _____ at _____ , California.

Type or print name _____

Signature _____