

STATE OF CALIFORNIA

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

INJURED WORKER INFORMATION

Panel #: _____

Date Request Received: _____ Date Mailed: _____
Claim No.: _____ Date of Injury: _____
Employer: _____ No. of Req.: _____
Claims Administrator: _____ Requested by: _____

To: _____

TYPE OF EXAM: () 4060 () 4061 () 4062 () 4061 and 4062

SELECTED QUALIFIED MEDICAL EVALUATOR PANEL:

PHYSICIAN'S NAME:

ADDRESS:

PHONE:

SPECIALTY:

YEARS IN PRACTICE:

PHYSICIAN'S EDUCATION:

PHYSICIAN'S TRAINING:

PHYSICIAN'S NAME:

ADDRESS:

PHONE:

SPECIALTY:

YEARS IN PRACTICE:

PHYSICIAN'S EDUCATION:

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PHYSICIAN'S NAME:

ADDRESS:

PHONE:

SPECIALTY:

YEARS IN PRACTICE:

PHYSICIAN'S EDUCATION:

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