

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

QME/AME REPORT TIME FRAME EXTENSION REQUEST

(Send to DWC Medical Unit 5 or more days before report is due.)

Request for 30 day extension
Reason ___ Lab or test results not received. Type of test: _____
___ Report of consulting physician not received.
Specialist type: _____

Request for 15 day extension
Reason ___ Medical emergency of the evaluator or evaluator family member.
___ Death in evaluator's family.
___ Natural disaster/other community catastrophe interrupted office.

Request extension for supplemental report

Date of Physical Evaluation: _____ Date Report will be served: _____

Employee's Name _____ Date of Injury _____

administrator

Claims Adjuster _____ Claim No. _____ Panel No. _____

QME Name _____ CA Lic. No. _____
(PRINT/TYPE)

QME Signature _____ Date _____

Street Address _____ City/Zip _____

Telephone _____ Fax _____

*File this form with the Division of Workers' Compensation-Medical Unit 5 days before your report is due to be served on the parties and send a copy of this form to the employee and ~~employer/insurer~~ claims administrator. The QME may not be entitled to payment for evaluations which are not submitted in a timely manner (Labor Code § 4062.5). **Review 8 Cal. Code Regs. § 34(h) for extension of supplemental report.** If you need further information, please call us at (510) 286-3700 or 1-800-794-6900.*

FOR DWC USE ONLY
() Extension approved () Extension denied and notice mailed to evaluator and parties
Medical Director: _____ Date _____



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