

STATE OF CALIFORNIA
Division of Workers' Compensation – Medical Unit
P.O. Box 71010, Oakland, CA 94612
(510) 286-3700 or (800) 794-6900

QUALIFIED OR AGREED MEDICAL EVALUATOR'S FINDINGS SUMMARY FORM

EMPLOYEE

1. Employee Name (First, Middle, Last): _____ 2. Social Sec. No. (Optional): _____ 3. Date of Injury _____
4. Street Address: _____ City: _____ Zip: _____ 5. Phone: _____

CLAIMS ADMINISTRATOR/EMPLOYER

6. Name: _____
7. Street Address: _____ City: _____ Zip: _____ 8. Phone: _____

EVENT DATES

9. Date of Appointment Call: _____ 10. Initial Examination Date: _____ 11. Date of Referral for Medical Testing/Consultation: _____
12. Date AME/QME's Report Served on all Parties: _____

DISPUTED MEDICAL ISSUES AND CONCLUSIONS

13. The following medical issues will be used to determine the patient's eligibility for workers' compensation.

		<i>(Check the appropriate box)</i>		
		Yes	No	Pending or Info. Not Sent
a.	Has the condition reached permanent and stationary status or maximum medical improvement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	Is there permanent impairment/disability?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Did work cause or contribute to the injury or illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	If permanent disability exists, is apportionment warranted?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	Is there a need for current or future medical care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f.	Can this employee now return to his/her usual job?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes:			
	i. Without restrictions	<input type="checkbox"/> Yes	<input type="checkbox"/> No,	If YES, Date: _____
	ii. With restrictions	<input type="checkbox"/> Yes	<input type="checkbox"/> No,	If YES, Date: _____

BASIS FOR CONCLUSIONS

(Check the appropriate box)

		Yes	No	Pending or Info. Not Sent
14.	Are there subjective complaints?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	Are there any abnormal physical or psychological examination findings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.	Are impairments described and measured using the AMA Guides?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. If the AMA Guides are used, are percentages of impairment stated?
18. Are there any relevant diagnostic test results (x-ray/laboratory)?
19. What are the diagnoses? (List) _____
-
20. Were medical records reviewed?
21. Were other physicians consulted? Yes No

QME

22. Signature: _____ Date: _____

23. Name: _____ Specialty: _____

24. Street Address: _____ City: _____ Zip: _____

25. Phone: _____ Cal. License No.: _____

Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))

I, _____, declare under penalty of perjury under the laws of the State of California that:
 (Print Name)

1. I am over the age of 18 and am employed by _____.
 (Name of Employer)

2. On _____, I served this QME or AME Summary Form with the attached medical-
 (Date)

legal report on each of the persons/firms named below, and by using the means of service, indicated below. I further declare that I am readily familiar with the practice of this office, named in (1), above, for collection and processing of correspondence for mailing, which is to deposit envelopes with the U.S. Postal Service on that same day with postage fully prepaid thereon at _____, _____ in the ordinary course of business.
 (City) (State)

I further declare that for service by mail, I either deposited this document personally in the U.S. Mail, or that I placed it for normal collection with the office stated in (1) above, in time for collection and processing that same day.

For service by messenger delivery: I further declare that I am familiar with the practice of the office stated in (1), above for messenger delivery, and I caused this document to be placed in a sealed envelope and to be delivered to a courier employed by _____ for personal delivery of each such envelope to the addressee, within two working days, at the address and on the date indicated in below:

<u>Means of service:</u> (e.g. U.S. mail/Certified mail/ Overnight mail/ Service by courier)	<u>Date:</u>	<u>Addressee and Address:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signed this _____ day of _____, 20____, in the county of _____, _____
 (State)

 (Signature of Declarant)

 (Print Name)

INSTRUCTIONS

To the QME or AME: You are required by Labor Code section 4062.3(i) to summarize the medical findings from your comprehensive medical-legal evaluation on the form prescribed by the Administrative Director. Please complete the form in its entirety.

Employee Information: Fill in the employee's full name, address, telephone number and date of injury.

Event Dates: Complete dates that patient called for an appointment, date of initial examination, date referred for consultation(s), if any, and date report served on all parties. Supplying these dates is a legal requirement.

Disputed Medical Issues and Conclusions: Complete this section by checking appropriate box and stating what page(s) or section of the medical legal report contain the narrative for details. If diagnostic or laboratory tests have been ordered and the results or a medical records request is pending, check that box. If you cannot render opinions because of pending information, please complete and serve the report to comply with the 30-day time requirement and state what issues could not be evaluated.

Basis for Conclusions: Check appropriate box and give page numbers or section where the narrative in the full report is found. For diagnoses, in addition to page numbers, please briefly summarize the diagnoses in lay terms where possible. Also, list the name and specialty for other physicians who provided information used in the medical legal report.

QME Signature: Remember under the Labor Code, all your reports must be signed under the penalty of perjury. You are required to serve the medical legal report and this form on the employee, the claims administrator (if none, the employer) and the Disability Evaluation Unit (DEU) having jurisdiction over the employee's area of residence.

Declaration of Service of Medical – Legal reports: Labor Code sections 139.2(j)(1)(A) and 4062.3 (i) and section 38 of Title 8 of the California Code of Regulations require the QME or AME to serve the medical-legal report and this form on the employer (or employer's claims administrator) and the injured worker within 30 days from the commencement of the examination, unless certain conditions are met. Please complete the proof of service to show the date the report was served on the parties.