

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT
P. O. Box 71010
Oakland, CA 94612
(510) 286-3700 or (800) 794-6900 Fax: (510) 622-3467

(date)

NOTICE OF DENIAL OF REQUEST FOR TIME EXTENSION

(Injured Employee or Attorney)
(address)

(Claims Administrator or Attorney)
(address)

Re: (Injured Employee name) v. (Employer/Insurer name)

Claim No. _____

QME Panel No.: _____

Name of QME/AME: _____

Evaluation Date (or Date of Request for Supplemental Report): _____

The request by the evaluator named above for an extension of time to complete a medical-legal evaluation report has been **denied** by the Medical Director of the Division of Workers' Compensation. The parties have two options: 1) you may wait for the report if both parties agree in writing to waive the lateness of the report; or 2) if either party does not agree to wait, you may agree on a new AME (represented cases only) or request a replacement panel QME. If you are represented by an attorney, consult your attorney.

Please advise the Medical Unit and the evaluator **within fifteen (15) days** of the date of this letter what you wish to do. Sign the form below, mail or fax it to the **Medical Unit at PO Box 71010, Oakland, CA 94612 (or fax (510) 622-3467)**, and send a copy to the evaluator. If you have any questions, please call the Medical Unit at (510) 286-3700 or 1-800-794-6900.

(Check one)

I wish to waive the lateness of this report and accept the report when it is done.

I request a new QME due to the lateness of the original QME, Agreed Panel QME or AME report. (For represented cases with an AME only, attach a copy of the first written proposal for one or more physicians to be an AME.)

Employee (or Attorney) Signature (Print name also) Date

Claims Administrator (or Attorney) Signature (Print name also) Date

cc: QME, Agreed Panel QME or AME

FOR DWC USE ONLY
Original panel source _____ Original panel specialty _____ Referral _____