

STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
MEDICAL UNIT
MAILING ADDRESS:
P. O. Box 71010
Oakland, CA 946123
(510) 286-3700 or (800) 794-6900 Fax: (510) 622-3467

**VOLUNTARY DIRECTIVE FOR ALTERNATE SERVICE OF MEDICAL-LEGAL
EVALUATION REPORT ON DISPUTED INJURY TO PSYCHE
(Unrepresented Employees Only)**

Injured Employee Name: _____
Date of Injury: _____
Claim No.: _____
WCAB Case No.: _____
Employer/Insurer: _____
Name of QME: _____
Date of Evaluation Exam: _____

I, _____,
(*print name of injured employee*)

understand I have a right to be served with a copy of the medical-legal evaluation report to be written about my case by the QME physician named above, at the same time as a copy of the report is sent to the employer or employer's insurer or claims agent and the Disability Evaluation Unit.

By signing below, I hereby direct that my copy of the medical/legal report be served by this medical evaluator on me as follows:

(*Check one*)

By sending a copy to me at my address on file AND sending a copy to the following physician who will review it with me and will be paid for an office visit for this purpose by my employer:

Physician Name: _____
Address: _____
City: _____ **Zip:** _____
Phone: _____

Only by sending a copy to me at my address on file.

I am signing this directive voluntarily and of my own free will:

(*Signature of Injured Employee*)

Date

Original of this signed form – attach to original medical-legal report
Copies of this signed form – to injured employee, employer/insurer/TPA, reviewing physician, QME