Reset Form | Print Form

State of California
Division of Workers' Compensation
Disability Evaluation Unit

REQUEST FOR CONSULTATIVE RATING

DEU Use Only

Indicate type of request:

☐ Mail-in ☐ Walk-in

INSTRUCTIONS FOR MAIL-IN'S:

1. Attach a photocopy of the medical report(s) for which a rating is being requested, if not previously on file. Do not send original reports.
2. Serve a copy of this request on the representative for the opposing party

INSTRUCTIONS FOR WALK-IN'S:

1. Attach this request form to copies of the medical reports that you wish to have rated.
2. List below the doctor's names and dates of reports to be rated.
3. If a deposition is to be rated, mark or list the pages to be reviewed by the rater.

SSN (Numbers Only) _____ Date of Birth _____ MM/DD/YYYY

Case Number 1 _____ Date of Injury 1 _____ MM/DD/YYYY

Case Number 2 _____ Date of Injury 2 _____ MM/DD/YYYY

Case Number 3 _____ Date of Injury 3 _____ MM/DD/YYYY

Case Number 4 _____ Date of Injury 4 _____ MM/DD/YYYY

Case Number 5 _____ Date of Injury 5 _____ MM/DD/YYYY

Injured worker

First Name _____ MI _____

Last Name _____ Suffix(Jr,Sr,etc) _____

Occupation (attach description if unclear) _____

RCR

Insurance Claim Number _____

Date of report(s) to be rated and doctor's name:

_____ _____
MM/DD/YYYY

_____ _____
MM/DD/YYYY

_____ _____
MM/DD/YYYY

This case has been set on for: _____ for the type of hearing checked below:
MM/DD/YYYY

☐ Rating MSC

☐ Trial

☐ Conference

Rating requested by:

_____
Name of firm

Representing the

☐ Employee ☐ Employer

A copy of this request has been served on

_____
Firm Name

_____
Firm Address 1/PO Box (Please leave blank spaces between numbers, names or words)

_____
Firm Address 2/PO Box (Please leave blank spaces between numbers, names or words)

_____ _____ _____
City State Zip Code