

State of California
Department of Industrial Relations
Division of Workers' Compensation
Request for Factual Correction of an
Unrepresented Panel QME Report

Person Requesting Correction _____ Employee Date of Birth _____ Date of Injury _____
(Required) (MM/DD/YYYY) (Required) (MM/DD/YYYY) (Required)

QME, Case and Report information

QME Name (Please leave blank spaces between numbers, names or words)

QME Street Address (Please leave blank spaces between numbers, names or words)

QME City _____ State _____ Zip Code _____ Panel Number _____ Date Report served
(MM/DD/YYYY)

Employee Information

Employee First Name: _____ MI _____ Employee Last Name: _____

Employee Street Address/PO Box (Please leave blank spaces between numbers, names or words)

Employee City (Please leave blank spaces between numbers, names or words) _____ State _____ Employee Zip Code _____

Employer and Claims Administrator Information (Required)

Employer Name (Please leave blank spaces between numbers, names or words)

Claims Administrator Company Name (Please leave blank spaces between numbers, names or words)

Claims Administrator Street Address/PO Box (Please leave blank spaces between numbers, names or words)

Claims Administrator City _____ State _____ Administrator Zip Code _____

Indicate the factual information that you believe is incorrect. **Do not attach any additional medical information to this form.** You may attach additional pages to point out the factual issues you believe need correction.

Date: (MM/DD/YYYY)

Signature

Proof of Service By Mail

I declare that:

I am a resident of or employed in the county where the mailing took place. I am over the age of eighteen years and my business or residence address is:

On _____, I served the attached the Request for Factual Correction by placing a true copy thereof enclosed in a sealed envelope with fully paid postage in the United State mail, addressed as follows:

Disability Evaluation Unit

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

City State Zip Code

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on:

Date: _____ at _____, California.
City

Type or print name _____

Signature _____