This packet is an example of the order in which documents should be filed. These are not examples of how to fill out forms/documents.

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET

Is this a new case? Yes ☐ No ☑ Companion Cases Exist ☐ Walkthrough Yes ☐ No ☑

More than 15 Companion Cases ☐

09/10/2008
Date:(MM/DD/YYYY)

SSN: [redacted]

DEU12345
Case Number 1

☑ Specific Injury ☐ Cumulative Injury

04/22/2004
(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

Please check unit to be filed on (check only one box)

☐ ADJ ☑ DEU ☐ SIF ☐ UEF ☐ VOC ☐ INT ☐ RSU

Companion Cases

☐ Specific Injury

Case Number 2

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

DOCUMENT SEPARATOR SHEET

Product Delivery Unit: DEU

Document Type: DEU FORMS

Document Title: REQUEST FOR SUMMARY RATING DETERMINATION - QME REPORT

Document Date: _____ MM/DD/YYYY

Date of document following Document Separator Sheet

If you are the Claims Administrator or the Hearing Representative use your Uniform Assigned Name. For Physician/Medical Provider, "Author" is the document author.

Author: UNIFORM ASSIGNED NAME

Office Use Only

Received Date: _____ MM/DD/YYYY

DWC-CA form 10232.2

REQUEST FOR SUMMARY RATING DETERMINATION

of Qualified Medical Evaluator's Report

State of California
Division of Workers' Compensation
Disability Evaluation Unit

DEU Use Only

INSTRUCTIONS TO THE CLAIMS ADMINISTRATOR:

1. Use this form if employee is unrepresented and has not filed an application for adjudication.
2. Complete this form and forward it along with a complete copy of all medical reports and medical records concerning this case to the physician scheduled to evaluate the existence and extent of permanent impairment or disability.
3. Send the EMPLOYEE'S DISABILITY QUESTIONNAIRE, DEU FORM 100 to the employee in time for the medical evaluation.
4. This form must be served on the employee prior to the evaluation. Be sure to complete the proof of service.

INSTRUCTIONS TO THE PHYSICIAN:

1. If the employee is unrepresented, review and comment upon the Employee's Disability Questionnaire, (DEU Form 100), in your report. (If the employee does not have a completed Form 100 at the time of the appointment, please provide the form to the employee.)
2. Submit your completed medical evaluation and, if the employee is unrepresented,the DEU Form 100, to the Disability Evaluation Unit district office listed below. PLEASE USE THIS FORM AS A COVER SHEET FOR SUBMISSION TO THE DISABILITY EVALUATION UNIT.
3. Serve a copy of your report and the Form 100 upon the claims administrator and the employee.

Date of first medical report indicating the existence of permanent impairment or disability:
Last date for which temporary disability indemnity was paid:

SUBMIT TO – Mailing Address:
Disability Evaluation Unit – Sacramento Suite 295 2424 Arden Way, Suite 230 Sacramento CA 95825-2403

PHYSICIAN: [redacted]
EXAM DATE: April 16, 2008

CLAIMS ADMINISTRATOR
Company: SCIF
Mailing Address: PO Box 3171
City, State, Zip: Suisun City CA 94585-6171
Claim No: [redacted]
Phone Number: [redacted]
Adjustor: [redacted]
EMPLOYER: [redacted]

EMPLOYEE
Name: [redacted]
Mailing Address: [redacted]
City, State, Zip: [redacted]
Date Of Injury: November 24, 2006
Date of Birth: December 18, 1964
Social Security#: [redacted]
WCAB Case No. (if any): [redacted]

OCCUPATION: SERVICE TECHNICIAN
(Please attach job description or job analysis, if available)

WEEKLY GROSS EARNINGS: $840.00 (Attach a wage statement/DLSR 5020 if earnings are less than maximum. Include the value of additional advantages provided such as meals, lodging, etc. If earnings are irregular or for less than 30 hours per week, include a detailed description of all earnings of the employee from all sources, including other employers, for one year prior to the date of injury. Benefits will be calculated at MAXIMUM RATE unless a complete and detailed statement of earnings is attached.)

RECEIVED
MAY 02 2008
P&S/Intake
DWC/DEU Sacramento

[redacted]

PROOF OF SERVICE BY MAIL

On 3-27-08 I served a copy of this Request for Summary Rating Determination on

(date)

[redacted] at [redacted] by placing

(name of employee) (address)

a true copy enclosed in a sealed envelope with postage fully prepaid, and deposited in the U.S. Mail. I declare under penalty of perjury under the laws of the State of California that the foregoing is ~~true~~ and correct.

Signature [redacted]

DEU Form 101
(Rev.06-05)

DOCUMENT SEPARATOR SHEET

Product Delivery Unit: DEU

Document Type: DEU FORMS

Document Title: EMPLOYEES PERMANENT DISABILITY QUESTIONAIRE

Date of document following Document Separator Sheet

Document Date: _____
MM/DD/YYYY

Author: INJURED WORKER NAME

Office Use Only

Received Date: _____
MM/DD/YYYY

DWC-CA form 10232.2

STATE OF CALIFORNIA
Division of Workers' Compensation
Disability Evaluation Unit
DEU Form 100 (Rev 4/05)

EMPLOYEE'S DISABILITY QUESTIONNAIRE

This form will aid the doctor in determining your permanent disability. Please complete this form and give it to the physician who will be performing the evaluation. The doctor will include this form with his or her report and submit it to the Disability Evaluation Unit, with a copy to you and your claims administrator.

Employee: [redacted]

Employer: Gil[redacted]

Social Security No: [redacted]

Nature of Employer's Business: [redacted]

Street and Number: [redacted]

City, State, Zip Code: C[redacted]

Claim Number: [redacted]

Date of Injury: November 24, 2006

Date of Birth: December 18, 1964

PLEASE ANSWER THE FOLLOWING QUESTIONS FULLY, using reverse side if needed:

How was your evaluating doctor selected? (Check one)

__✓__ From a list of doctors provided by the State of California, Division of Workers' Compensation.

_____ Other (explain) _____

What is the name of the doctor who will be doing the evaluation? [redacted]

When is your examination scheduled? APRIL 16, 2008 1:00 PM

What were your job duties at the time of your injury?
replacing Air Cond. Technical Diagnostic (Roof. attic. Ground) installing equip.

What is the disability resulting from your injury?
Can not grip especially skinny items, Can't make a fist Can't hold multiple items etc.

How does this disability affect you in your work?
Can't Climb wall ladders. hard to Crawl Can't brake lines screws bolts. lift heavy items

Have you ever had a permanent disability as a result of another injury or illness? NO If so, when?

Please describe the disability? N/A

Sign here [redacted] Date: 4/16/08

SCIF e3132(REV. 7-05)

8

1226

DOCUMENT SEPARATOR SHEET

Product Delivery Unit: DEU

Document Type: MEDICAL REPORTS

Document Title: PANEL QME (NON-REPRESENTED ALL DOI)

Document Date: 04/16/2008
MM/DD/YYYY

Author: [redacted]

Office Use Only

Received Date: _____
MM/DD/YYYY

DWC-CA form 10232.2

[redacted] [redacted] [redacted]

Comprehensive Medicolegal Examination on [redacted]

April 16, 2008

DOI: November 24, 2006
EMP: [redacted]
CL#:

Introduction

This 43 year old man is seen for the evaluation of disability in his right upper extremity. He has selected this office from a list of Qualified Medical Examiners. We have received the medical file from [redacted] All of the reports have been reviewed.

This evaluation is carried out according to the *AMA Guides to the Evaluation of Permanent Impairment*, fifth edition, chapter 16, the Upper Extremity. The *Guides* are based on anatomic impairment rather than subjective factors that are difficult to control. (Section 16.8)

Work History

The applicant worked for [redacted] until [redacted] He was terminated following his injury. He has not worked again since then.

Work Description

The applicant was a service technician. He drove a service van. He repaired air conditioners and furnaces. He worked 50 to 60 hours a week.

Medical History

The applicant denies ever having any significant injuries or symptoms involving the right upper extremity prior to the onset of the difficulty that is the subject of this report.

History of Injury

The date of injury is November 24, 2006. The applicant was removing a gas valve from a furnace. He had a pair of channel locks which means a big pair of pliers. He felt something give out in his right hand. That night his hand swelled up. When he went back to work, they sent him to Rapid Care. He worked only about one or two days after the injury.

Review of Medical Records

November 28, 2006: [redacted] Rapid Care. Cameron Park.
Taking a gas valve apart – felt R wrist pain. Examination: R wrist tender over dorsal ulna. Diagnosis: Strain R wrist. Treatment: Velcro splint. Naprosyn, start 2x day.

December 30, 2006: [redacted]
Right hand: Three views. Normal hand.

January 29, 2007: [redacted] Orthopedics. Placerville.
He complains of pain that is 10/10 on the ulnar aspect of his hand and wrist. He has little active motion of the fifth digit. Phalen's test is very positive. Mr. Stiles does present with a bit of a diagnostic dilemma.

February 13, 2007: [redacted]
The patient's clinical presentation is confusion. I will recommend modified work.

March 24, 2007: [redacted]
R MRI hand and wrist. Severe tenosynovitis involving the flexor digitorum tendons and the flexor pollicis longus. Nondisplaced fracture proximal phalanx, little finger. Defect in the scapholunate ligament and triangular fibrocartilage.

April 4, 2007: [redacted] Physical Medicine & Rehabilitation.
Electrical studies. Evidence of median and ulnar nerve dysfunction across the right wrist.

April 4, 2007: [redacted]
Same address and suite, 410, as [redacted] Thank you for this interesting referral.

April 12, 2007: [redacted]
The patient's hand is getting worse. X-rays of the right hand – possibly healed fracture of the small finger. At this time it is really impossible to make a diagnosis.

April 27, 2007: [redacted]
RA titer. Result – 5

April 27, 2007: [redacted]
At this time it is really possible (sic) to make a diagnosis.

June 21, 2007: [redacted]
At this time it is really possible (sic) to make a diagnosis.

July 31, 2007: [redacted] Rheumatology
The current findings implicate some type of chronic inflammatory arthropathy/tendinopathy. Rheumatoid testing might include repeat rheumatoid factor. I cannot provide a definitive diagnosis or recommendations. Rheumatologic surveillance would be somewhat difficult until worker's compensation issues are resolved.

August 2, 2007: [redacted]
X-rays: Four views of the right small finger. Normal appearance of the phalanges. At this time it is really possible (sic) to make a diagnosis. I recommend that we proceed with surgery.

September 13, 2007: [redacted]
At this time it is really possible (sic) to make a diagnosis. He is scheduled for surgery.

September 17, 2007: [redacted]
Surgery under Bier block. Release of right carpal tunnel.

September 17, 2007: [redacted]
Pathology report. Right wrist synovium. This suggests the possibility of rheumatoid arthritis.

October 7, 2007: [redacted]
Slight opening of his wrist wound.

October 10, 2007: [redacted]
He has an open wound over the surgical site ½" long by ¼" wide. We will monitor the wound.

Undated: [redacted]
[redacted] still has an open wound over the surgical site.

October 26, 2007: [redacted]
The wound in the palm is closing.

December 4, 2007: [redacted]
He still needs to do therapy.

January 10, 2008: [redacted]
He needs to continue therapy.

January 20, 2008: [redacted]
Request for physical therapy was DENIED.

Interval Status

The applicant saw [redacted] at the end of March. He just looked at everything. He said to come back in six weeks. The applicant has another appointment in a week and a half. Thus far the applicant has had 27 sessions of physical therapy. He took it until a month ago. In terms of medication, the applicant takes Celebrex 200 mg twice a day.

Present Problems

The fingers do not bend at the end indicating the distal finger joints. That is as far as the pinkie can go down indicating limited flexion in the little finger. He has no grip on small objects. If he makes a fist and tries to flex the pinkie, his other fingers come up. If he rotates his hand to break bolts, he doesn't have much strength. When he tries to twist a nut, he doesn't have much strength. It makes his wrist swell up.

After the injury, he had numbness in the fingers but all the numbness has gone away. The numbness involved the long, ring and little fingers.

He hasn't had any night symptoms for five or six months.

General Appearance

The applicant gives his height as 5' 11". On our office scale today including all his clothing, he weighs 177 pounds.

The applicant is right handed.

Examination of the Right Upper Extremity

There is no limitation of motion at the shoulder or elbow.

Compression of the ulnar nerve at the elbow causes tingling in the little finger.

Forearm circumference is 10 7/8" on each side at the same level.

It can be demonstrated that there is decreased muscular tonus in the area of the right forearm that is supplied with the ulnar nerve compared with the opposite forearm.

There is limitation of motion at the wrist as noted on Figure 16-1a.

There is a vertical scar over the proximal palm extending into the forearm. The forearm component of the scar is 1" in length. The component of the scar in the palm is also 1".

The tests for carpal tunnel syndrome were carried out. Maximum comfortable flexion of the wrist does not cause any sensory alteration in the digits. Tapping over the median nerve at the wrist does not cause a shock.

On lightly stroking the tips of the digits of the right hand and comparing with the left hand, there is no sensory impairment in any of the digits.

On flexion of the fingers, there is considerable impairment of flexion in the little finger. There is impairment of flexion in the other fingers to a lesser degree. This is documented on Figure 16-1b. There is considerable atrophy of the hypothenar eminence which is the muscular area at the ulnar side of the palm. There is considerable weakness of adduction in the little finger.

His grips with the Jamar dynamometer are:

Right	-	75, 68, 50
Left	-	135, 140, 132

X-rays

We have obtained views of both hands and wrists. In comparing the minialization in the bones of the right forearm, wrist and hand, there is no significant difference from the left hand.

Diagnosis

Right cubital tunnel syndrome.

Future Medical

The appropriate form of treatment in this situation is release of the right cubital tunnel. However, it was explained to the applicant that the condition has existed for so long that the possibility of regaining muscularity in the involved muscles is slight. In other words, the prognosis for recovery of function is not particularly good. It should be clear by now that physical therapy has nothing to offer in this situation.

Work Restrictions

The applicant is disabled from returning to his former employment which was working in heating and air conditioning.

Vocational Rehabilitation

The applicant is a qualified injured worker and should be offered vocational rehabilitation.

Apportionment

There are no factors of apportionment to preexisting or nonindustrial causes.

Industrial Causation

The cubital tunnel syndrome was not caused by the injury that is described as the date of

the industrial injury. The nerve compression had a gradual onset but apparently remained silent as it often does for some period of time. The event with the channel locks focused attention on the difficulty in the extremity. This remained undiagnosed through a long series of medical visits.

It is interesting to note that the nerve compression was touched upon by the report of Dr. Dengler dated April 4, 2007. Electrical studies were reported as showing evidence of median and ulnar nerve dysfunction across the right wrist.

The fact that there was ulnar nerve dysfunction was accurate but the level of the lesion was not correct. It was actually at the elbow.

All this was explained to the applicant. Then I showed him a picture from the Journal of the American Medical Association entitled *Cubital Tunnel Syndrome*. The picture showing impairment of flexion in the little finger was virtually identical to the condition of this individual's hand.

In summary, the cubital tunnel syndrome was caused by the stresses of his employment. The causation is industrial.

Factors of Impairment

These are noted on Figures 16-1a and 16-1b. The whole person impairment is 10%.

Disability Status

The applicant has reached maximum medical improvement.

Declaration

There has not been a violation of Section 139.3 and the contents of the report are true and correct to the best of my knowledge. This statement is made under the penalty of perjury.

Furthermore, I certify that this report has been prepared in accord with the *California Code of Regulations*, Title 8, Section 10606, Physicians' Reports as Evidence.

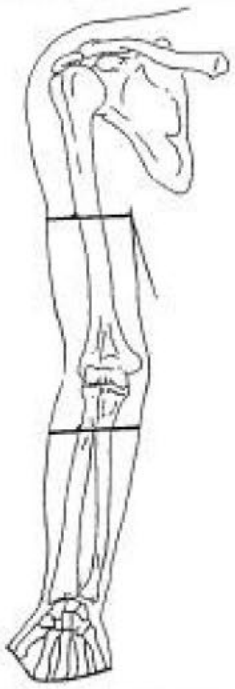
This declaration was signed on April 18, 2008 at Placer County, California.

Figure 16-1b Upper Extremity Impairment Evaluation Record—Part 2 (Wrist, elbow, and shoulder) Side ☒R ☐L

Name [redacted] Age [redacted] Sex ☒M ☐F Dominant hand ☒R ☐L Date April 16, 2008

Occupation [redacted] Diagnosis Right cubital tunnel syndrome

Abnormal Motion					Other Disorders	Regional Impairment %	Amputation
Record motion or ankylosis angles and impairment %					List type & impairment %	•Combine [1] + [2]	Mark level & impairment %
Wrist	Flexion	Extension	Ankylosis	Imp %			
Angle°	45	55					
Imp %	2.5	1		3.5			
	RD	UD	Ankylosis	Imp %			
Angle°	20	15					
Imp %	0	3		3			
Add Imp % Flex/Ext + RD/UD = 6.5				[1]	Imp % = [2]		
Elbow	Flexion	Extension	Ankylosis	Imp %			
Angle°							
Imp %							
	Pronation	Supination	Ankylosis	Imp %			
Angle°							
Imp %							
Add Imp % Flex/Ext + Pro/Sup =				[1]	Imp % = [2]		
Shoulder	Flexion	Extension	Ankylosis	Imp %			
Angle°							
Imp %							
	Adduction	Abduction	Ankylosis	Imp %			
Angle°							
Imp %							
	Int Rot	Ext Rot	Ankylosis	Imp %			
Angle°							
Imp %							
Add Imp % Flex/Ext + Add/Abd + Int Rot/Ext Rot =				[1]	Imp % = [2]		Imp % =



I. Amputation impairment (other than digits)	=	%
II. Regional impairment of upper extremity •(Combine hand 10 % + wrist 6.5 % + elbow ____ % + shoulder ____ %)	=	16 %
III. Peripheral nerve system impairment	=	%
IV. Peripheral vascular system impairment	=	%
V. Other disorders (not included in regional impairment)	=	%
Total upper extremity impairment (•Combine I, II, III, IV, and V)	=	16 %
Impairment of the whole person (Use Table 16-3)	=	10 %

• Combined Values Chart (p. 604).

If both limbs are involved, calculate the whole person impairment for each on a separate chart and combine the percents (Combined Values Chart).

[redacted]

April 18, 2008

Figure 16-1a Upper Extremity Impairment Evaluation Record–Part 1 (Hand) Side ☒R ☐L

Name: [redacted] Age [redacted] Sex ☒M ☐F Dominant hand ☐R ☐L Date April 16, 2008

Occupation: [redacted] Diagnosis: Right cubital tunnel syndrome

			Abnormal Motion: Record motion or ankylosis angles and digit impairment %				Amputation: Mark level & impairment %	Sensory Loss: Mark type, level, & impairment %	Other Disorders: List type & impairment %	Hand Impairment %: *Combine digit imp % *Convert to hand imp %
			Flexion	Extension	Ankylosis	Imp %				
Thumb	IP	Angle°								
		Imp %								
	MP	Angle°								
		Imp %								
				Motion	Ankylosis	Imp %				
	CMC	Radial abduction Angle°								
		Radial abduction Imp %								
		Adduction Cm								
		Adduction Imp %								
		Opposition Cm								
		Opposition Imp %								
							*UE IMP % = [5]			Abnormal motion [1]
										Amputation [2]
										Sensory loss [3]
										Other disorders [4]
										Total digit imp % *Combine 1, 2, 3, 4
Add digit impairment % CMC + MP + IP =						[1]	Digit [2] IMP % =	Digit [3] IMP % =	Digit [4] IMP % =	Hand impairment % *Convert above
			Flexion	Extension	Ankylosis	Imp %				
Index	DIP	Angle°	60							Abnormal motion [1]
		Imp %	5			5				Amputation [2]
	PIP	Angle°	100							Sensory loss [3]
		Imp %	0			0				Other disorders [4]
	MP	Angle°	75							Total digit imp % *Combine 1, 2, 3, 4
		Imp %	8.5			8.5				13
*Combine digit impairment % MP, PIP, DIP = 13						[1]	Digit [2] IMP % =	Digit [3] IMP % =	Digit [4] IMP % =	Hand impairment % *Convert above
										3
Middle	DIP	Angle°	70							Abnormal motion [1]
		Imp %	0			0				Amputation [2]
	PIP	Angle°	100							Sensory loss [3]
		Imp %	0			0				Other disorders [4]
	MP	Angle°	65							Total digit imp % *Combine 1, 2, 3, 4
		Imp %	3			3				3
*Combine digit impairment % MP, PIP, DIP = 3						[1]	Digit [2] IMP % =	Digit [3] IMP % =	Digit [4] IMP % =	Hand impairment % *Convert above
										1
Ring	DIP	Angle°	60							Abnormal motion [1]
		Imp %	5			5				Amputation [2]
	PIP	Angle°	100							Sensory loss [3]
		Imp %	0			0				Other disorders [4]
	MP	Angle°	75							Total digit imp % *Combine 1, 2, 3, 4
		Imp %	8.5			8.5				13
*Combine digit impairment % MP, PIP, DIP = 13						[1]	Digit [2] IMP % =	Digit [3] IMP % =	Digit [4] IMP % =	Hand impairment % *Convert above
										1
Little	DIP	Angle°	45							Abnormal motion [1]
		Imp %	12.5			12.5				Amputation [2]
	PIP	Angle°	45							Sensory loss [3]
		Imp %	33			33				Other disorders [4]
	MP	Angle°	30							Total digit imp % *Combine 1, 2, 3, 4
		Imp %	35			35				60
*Combine digit impairment % MP, PIP, DIP = 60						[1]	Digit [2] IMP % =	Digit [3] IMP % =	Digit [4] IMP % =	Hand impairment % *Convert above
										6

Total hand impairment: Add hand impairment % for thumb + index + middle + ring + little finger =	11 %
Convert total hand impairment to upper extremity impairment† (if thumb metacarpal intact, enter on Part 2, line II) =	10 %
†Add thumb ray upper extremity amputation imp [5] ____% + hand upper extremity imp ____% =	%
If hand region impairment is only impairment, convert upper extremity impairment to whole person impairment§ =	%

• Combined Values Chart (p. 604). *Use Table 16-1 (digits to hand). †Use Table 16-2 (hand to upper extremity). §Use Table 16-3.
Courtesy of G. de Groot Swanson, MD, Grand Rapids, Michigan.

[redacted]

April 18, 2008

Department of Industrial Relations, Industrial Medical Council, PO Box 8888, San Francisco, CA 94128• (650) 737-2767

State of California

Qualified or Agreed Medical Evaluator's Findings Summary Form

Employee

1. Employee Name (First, Middle, Last) [redacted] 2. Social Sec No.(Optional) [redacted] 3. Date of Injury (Mo/ Dy /Yr) [redacted]

4. Street Address [redacted] City Zip 5. Telephone [redacted]

Claims Administrator/ Employer

6. Name : State Comp. Ins. Fund

7. Street Address: P.O. Box 3171, City: Suisun City, CA Zip: 94585-6171 8. Telephone: 916.924.5100

Exam Referral Schedule

9. Date of Appointment Call: 3.11.2008 10. Date of Initial Examination: 4.16.2008 11. Date of Referral for Medical Testing/Consultation:

12. Date AME/QME's Report Served on all Parties: 4.18.2008

Disputed Medical Issues And Conclusion

13. The following medical issues will be used to determine the patient's eligibility for workers' compensation. Check the appropriate box and reference the corresponding page(s) or section of the med-legal report for details.

	Report page(s) or section	Yes	No	Pending or Info. Not Sent
a. Is there permanent disability?	7	☑	☐	☐
b. Is the medical condition stable and not likely to improve with active medical or surgical treatment (i.e., is the condition permanent and stationary)?	7	☑	☐	☐
c. Did work cause or contribute to the injury or illness?	6	☑	☐	☐
d. If permanent disability exists, is apportionment warranted?	6	☐	☑	☐
e. Is there a need for current or future medical care?	6	☑	☐	☐

f. Can this employee now return to his/her usual job? ☐ Yes ☑ No

If yes:

i. Without restrictions ☐ Yes ☐ No, If YES, Date: _____

ii. With restrictions ☐ Yes ☐ No, If YES, Date: _____

If restricted work is recommended, reference page(s)/section in report for details: _____

Basis for Conclusions

Check box and refer to page(s) or section in report.

	Report page(s) or section	Yes	No	Pending or Info. Not Sent
14. Are there subjective complaints?	4	☑	☐	☐
15. Are there any abnormal physical or psychological examination findings?	5	☑	☐	☐
16. Are there any relevant diagnostic test results (x-ray/laboratory)?	6	☑	☐	☐

17. What are the diagnoses? (List) Right cubital tunnel syndrome.

18. Were treating physician's reports reviewed?	2-4	☑	☐	☐
19. Were other physicians consulted?	____	☐ Yes	☑ No	

QME

20. Signature [redacted] Date: April 18, 2008

21. Name [redacted] Specialty General

22. Street Address [redacted] City [redacted] Zip [redacted]

23. Telephone [redacted] Cal. # [redacted]