STATE OF CALIFORNIA

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

INJURED WORKER INFORMATION

Panel #:_____

Date Request Received: Date Mailed:

Claim No.: Date of Injury:

Employer: No. of Req.:

Claims Administrator: Requested by:

To:

TYPE OF EXAM: ☐ **4060** ☐ **4061** ☐ **4062** ☐ **4061 and 4062**

SELECTED QUALIFIED MEDICAL EVALUATOR PANEL:

PHYSICIAN'S NAME:
ADDRESS: PHONE:
SPECIALTY:
YEARS IN PRACTICE:
PHYSICIAN'S EDUCATION:
PHYSICIAN'S TRAINING:

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