

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.:** \_\_\_\_\_

**EAMS or WCAB Case No.:** \_\_\_\_\_

**Claims Administrator:** \_\_\_\_\_

**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 written about my case by the QME physician named above, at the same time as a copy of the report is sent to the claims administrator and/or the Disability Evaluation Unit.

By signing below, I hereby direct that the QME serve my copy of the medical/legal report in the following manner:

(Check one)

- By sending my copy to the following physician who will review it with me and will be paid for an office visit for this purpose by the claims administrator, or if none by my employer. The physician I name below may be my primary treating physician in this case or any other physician I wish to designate. At the end of that visit, the physician named below will give me my copy of the report:

**Physician Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

- Only by sending a copy to me at my address on file. I do not wish to designate a physician to review it with me.

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

\_\_\_\_\_  
(Signature of Injured Employee)

\_\_\_\_\_  
Date