Reset Form Print Form

DIVISION OF WORKERS' COMPENSATION
REQUEST FOR RECONSIDERATION OF SUMMARY RATING BY THE ADMINISTRATIVE DIRECTOR

This form may be used by an unrepresented employee or his or her employer to request that the Administrative Director determine whether a permanent disability rating issued by the Disability Evaluation Unit should be reconsidered pursuant to Labor Code section 4061(g).

A request for reconsideration may be granted if it is shown that the Qualified Medical Evaluator (QME) or Primary Treating Physician (PTP) has failed to address all issues, failed to completely address issues, failed to follow the medical evaluation procedures promulgated by the Administrative Director, or if the rating was incorrectly calculated.
This procedure is applicable only to injuries occurring on or after 1/1/91. Please verify that you sent a copy of this request to the other party (employee or claims administrator) by filling out the proof of service below after reading the instructions on the reverse side.

This request must be submitted within thirty (30) days of receipt of the rating.

SEND TO: Administrative Director
Division of Workers' Compensation
Attn: Summary Rating Reconsideration
P.O. Box ~~42060370823~~
~~San Francisco~~Oakland, CA ~~9414294612~~

INCLUDE: (1)This completed form;
(2)Other information supporting the request.

Employee

First Name _____ MI _____

Last Name _____

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

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

International Address (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Employer / Adjusting Agency

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

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

City _____ State _____ Zip Code _____

Disability Evaluation Unit Case Number

Claim Number

SSN (Numbers Only)

Date of Injury _____
MM/DD/YYYY

REASON(S) FOR REQUEST: (Check reason and explain below. Attach additional sheets if necessary.)

- ☐ QME/PTP failed to address all issues
- ☐ QME/PTP failed to completely address issues
- ☐ Evaluation procedures not followed by QME/PTP
- ☐ Rating was incorrectly calculated

Explanation

Reconsideration of Summary Rating is being requested by:

- ☐ Injured worker
- ☐ Employer/Adjusting Agency

Name

PROOF OF SERVICE BY MAIL (Instructions on next page)

On _____, I served a copy of this Request for Reconsideration of Summary Rating on

Address

City State Zip Code

by placing 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

INSTRUCTIONS FOR COMPLETING THE PROOF OF SERVICE BY MAIL

Complete the Proof of Service By Mail

PROOF OF SERVICE BY MAIL (SAMPLE)

(# 1)

On _____ I served a copy of this Request for Reconsideration of Summary Rating on
MM/DD/YYYY

_____ (# 2)
(name of employee or claims administrator)

_____ (# 3)
Address/PO Box (Please leave blank spaces between numbers, names or words)

_____ _____ _____
City State Zip Code

by placing 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 _____ (# 4)

1) List on line #1 the date on which you mailed this form.

2) If you are the Injured Employee, list on line #2 the name of the Insurance Carrier or Claims Adjusting Agency handling your case. If you are the Insurance Carrier/Claims Adjusting Agency, list the name of the Injured Employee.

3) List on line #3 the mailing address for the Insurance Carrier/Claims Adjusting Agency or Injured Employee you listed on line #2.

4) Sign your name on line #4.