

# Qualified Medical Evaluator Complaint Form

Department of Industrial Relations  
Division of Workers' Compensation - Medical Unit  
P. O. Box 71010  
Oakland, CA 94612

## **Instructions for Completing this Complaint Form**

1. Legibly print or type all information.
2. Provide the name of the Qualified Medical Evaluator and the date of the evaluation.
3. Provide the address where the evaluation was performed.
4. If you are complaining about the contents of the report or the way the evaluation was conducted, please include the medical report of the QME, if available.
5. Please sign and date the complaint form.

**NOTICE:** Except for the name of the physician, the remainder of the information requested is voluntary; however, the failure to provide the requested information may delay or prevent the investigation of your complaint. Please provide as much information as possible in your complaint. The Division of Workers' Compensation will use the information in your complaint in part to determine whether a violation of state law has occurred. If a violation is substantiated, the information may be transmitted to other government agencies.

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(For DWC use only)

**COMPLAINT AGAINST**

Physician's First Name

Physician's Last Name

Address where the Evaluation took place

City

Zip Code

Phone Number

Date of Evaluation

QME Panel Number

Panel Qualified Medical Evaluation

Agreed Medical Evaluation

**COMPLAINANT**

First Name

Last Name

Mailing Address

City

State

Zip Code

Daytime Phone Number

Fax Number

E-mail Address

*If you are making a complaint and you are not the injured worker, please list the name of the injured worker.*

Name of Injured Worker:

**INFORMATION ABOUT THE CLAIM**

*If you are the injured worker, please list the name of the insurance company/employer and the name and telephone number of your claims adjuster.*

Name of Claims Adjuster

Phone Number of Claims Adjuster

Insurance Company or Employer

Claim Number

*If your complaint involves an examination performed by a Qualified Medical Examiner in a case pending before the Workers' Compensation Appeals Board, please list the case and the case number. If the WCAB has held a hearing or issued any orders about this examination, please attach the minutes of hearing or the Board order to this complaint.*

Case Name

Case Number(s)

**GIVE US THE DETAILS OF YOUR COMPLAINT**

Please list the details of your complaint and attach any documents that you believe would be useful for the investigation. Use as many additional sheets of paper as necessary to tell us about your complaint.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature