STATE OF CALIFORNIA
Division of Workers' Compensation
Disability Evaluation Unit

DEU Use Only

EMPLOYEE'S DISABILITY QUESTIONNAIRE

This form will aid the doctor in determining your permanent impairment or 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

First Name _____ MI _____

Last Name _____

SSN (Numbers Only) _____

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 _____

Date of Birth _____ MM/DD/YYYY

Date of Injury _____ MM/DD/YYYY

Employer _____

Nature of Employers Business _____

Claim Number 1 _____