* D E U 1 0 1 *

State of California
Division of Workers' Compensation
Disability Evaluation Unit

DEU Use Only

REQUEST FOR SUMMARY RATING DETERMINATION of Qualified Medical Evaluator's Report

INSTRUCTIONS TO THE CLAIMS ADMINISTRATOR:

1. Use this from if employee is unrepresented and has not filed an application for adjudication.
2. Complete this form and forward it along with a complete copy of all medical reports and medical records concerning this case to the physician scheduled to evaluate the existence and existence and extent of permanent impairment or disability.
3. Send the EMPLOYEE'S DISABILITY QUESTIONNAIRE, DEU FORM 100 to the employee in time for the medical evaluation.
4. **This form must be served on the employee prior to the evaluation. Be sure to complete the proof of service.**

INSTRUCTIONS TO THE PHYSICIAN:

1. If the employee is unrepresented review and comment upon the Employee's Disability Questionnaire, (DEU Form 100), in your report. (If the employee does not have a completed Form 100 at the appointment, please provide the form to the employee.)
2. Submit your completed medical evaluation and, if the employee is unrepresented, the DEU Form 100, to the Disability Evaluation Unit district office listed below. **PLEASE USE THIS FORM AS A COVER SHEET FOR SUBMISSION TO THE DISABILITY EVALUATION UNIT.**
3. Serve a copy of your report and the Form 100 upon the claims administrator and the employee.

Date of first medical report indicating the existence of permanent impairment disability: ______________________
MM/DD/YYYY

Last date for which temporary disability indemnity was paid: ______________________
MM/DD/YYYY

Submit To: Disability Evaluation Unit

____
Address/PO Box (Please leave blank spaces between numbers, name or words)

______________________________________ ______ __________
City State Zip

____
Physician

Exam Date ______________________
MM/DD/YYYY