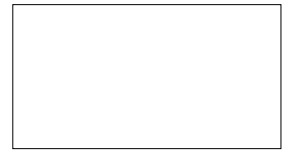


State of California
Division of Workers' Compensation
Disability Evaluation Unit



DEU Use Only

* D E U 1 0 1 *

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

INSTRUCTIONS TO THE CLAIMS ADMINISTRATOR:

1. Use this form 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 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