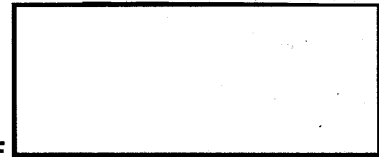




**STATE OF CALIFORNIA
Division of Workers' Compensation
Disability Evaluation Unit**



EMPLOYEE'S DISABILITY QUESTIONNAIRE

DEU Use Only

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

