Claim Number 2 _____

Claim Number 3 _____

Claim Number 4 _____

Claim Number 5 _____

PLEASE ANSWER THE FOLLOWING QUESTIONS FULLY:
How was your evaluating doctor selected? (check one)

☐ From a list of doctors provided by the State of California, Division of Workers' Compensation.

☐ Other (explain) _____

What is the name of the doctor who will be doing the evaluation? _____

When is your examination scheduled? _____

What were your job duties at the time of your injury?

What is the disability resulting from your injury?

How does this injury affect you in your work?

Have you ever had a disability as a result of another injury or illness? _____

If so, when? _____

Please describe the disability?

Date _____ Signature _____
MM/DD/YYYY