STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT
MAILING ADDRESS:
P. O. Box 71010
Oakland, CA 94612
(510) 286-3700 or (800) 794-6900 Fax: (510) 622-3467

QME APPOINTMENT NOTIFICATION FORM

To the Qualified Medical Evaluator: You are required by law to give notice on this form when an appointment has been made with you to perform a QME comprehensive medical evaluation. Please complete this form in its entirety. You are legally required to include: the name and address of the employee, the name of the employer and claims administrator, and the appointment time and date. The Administrative Director also requires that you serve this appointment notification form on the employee and the claims administrator, or if none the employer, and their attorneys in a represented case, if known, within five (5) business days after having scheduled the injured worker to be seen for a QME comprehensive medical evaluation. You also must use this form if you refer the injured worker for a consultation to advise the parties of the date and time of the appointment with the consulting physician (See, 8 Cal. Code Regs. § 32). You may not cancel the appointment less than six (6) calendar days prior to the appointment date, except for good cause (See, 8 Cal. Code Regs. §34). If you reschedule an appointment, review regulation 34 and the ethical rules in regulation 41 (See, 8 Cal Code Regs. §§ 34 and 41(a)(7) and (a)(8)).

EMPLOYEE INFORMATION

NAME:_____

ADDRESS:_____
City *State* *Zip*

PHONE:_____ SOCIAL SECURITY No.:_____
(Social Security Number is for record-keeping purposes only.)

DATE OF INJURY:_____ PANEL No.:_____ CLAIM/CASE No.:_____

EMPLOYER INFORMATION

NAME:_____

ADDRESS:_____
City *State* *Zip*

PHONE:_____

CLAIMS ADMINISTRATOR INFORMATION

NAME:_____

COMPANY:_____

ADDRESS:_____
City *State* *Zip*

PHONE:_____

APPOINTMENT INFORMATION

DATE OF APPOINTMENT CALL_____ DATE OF APPOINTMENT_____ TIME OF APPOINTMENT_____

LOCATION OF APPOINTMENT:_____

CERTIFIED INTERPRETER REQUIRED: (LANGUAGE)_____

COPY TO: ☐ EMPLOYEE (and employee's attorney, if known)

☐ CLAIMS ADMINISTRATOR (and attorney, if known)

SIGNATURE OF QME:_____

QME NAME (print/type):_____

ADDRESS AND PHONE:_____

Note to Claims Administrator: The Administrative Director's regulation 10160 requires you to forward a completed, DWC-AD form 101(DEU)(Request for Summary Rating Determination of Qualified Medical Evaluator's Report) (see, 8 Cal. Code Regs. § 10160 and 10161) together with all medical reports and medical records prior to the scheduled examination with the QME. You must also provide the employee with a DWC-AD form 100 (DEU)(Employee's Disability Questionnaire)(See, 8 Cal. Code Regs. §§ 10160 and 10161) prior to the examination.