

State of California
Division of Workers' Compensation-Medical Unit
QME Appointment Notification Form

Please complete this form in its entirety. The Administrative Director 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-legal evaluation. 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, 41(a) (7) and (a)

Employee Information *(Completion of this section is required)*

Employee Name _____		Phone Number _____	
Employee Street Address _____	Employee City _____	State _____	Zip Code _____
Date of Injury _____	Panel Number _____	Claim or Case Number _____	

Employer Information

Employer Name _____			
Employer Street Address _____	Employer City _____	State _____	Zip Code _____

Claims Administrator Information *(Completion of this section is required)*

Claims Administrator Name (Insert the name of the person handling the claim) _____		Phone Number _____	
Claims Administrator Company (Insert the name of the company handling the claim) _____			
Claims Administrator Street Address _____	Claims Administrator City _____	State _____	Zip Code _____

Appointment Information *(Completion of this section is required)*

Date of appointment call: _____ Date of Appointment: _____ Time of appointment: _____

Examination address _____ Examination City: _____ Zip Code _____

Records should be sent to the following address: _____
Street address or P.O. Box _____ City: _____ Zip Code _____

Is a certified interpreter required? Yes No If an interpreter is required, indicate language: _____

QME Name: _____

QME Street Address _____	QME City _____	State _____	Zip Code _____
--------------------------	----------------	-------------	----------------

Date Signed: _____ Signature of the QME: _____

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.

Declaration of Service

I declare that I am a resident of or employed in the county where the mailing took place. I am over the age of eighteen years and I am not a party to this case, my business or residence address is:

On _____, I served this QME Appointment Notification Form, the original, or a true and correct copy of the original, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

- A depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.
- B placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.
- C placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.
- D placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*
- E personally delivering the sealed envelope to the person or firm named below at the address shown below.

Method of Service	Person or firm served	Street Address
	City	State Zip Code

Method of Service	Person or firm served	Street Address
	City	State Zip Code

Method of Service	Person or firm served	Street Address
	City	State Zip Code

Method of Service	Person or firm served	Street Address
	City	State Zip Code:

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: _____ at _____, California.

Type or print name _____

Signature _____