

State of California Division of Workers' Compensation Disability Evaluation Unit

REQUEST FOR CONSULTATIVE RATING

DEU Use Only	

ndicate type of request:			
Mail-in Walk-in			
NSTRUCTIONS FOR MAIL-IN'S:			
Attach a photocopy of the medical repsend original reports. Serve a copy of this request on the rep			on file. Do not
NSTRUCTIONS FOR WALK-IN'S:			
 Attach this request form to copies of the List below the doctor's names and date If a deposition is to be rated, mark or I 	es of reports to be rated.		
	Date of Birth		
SSN (Numbers Only)	_	MM/DD/YYYY	-
	Date of Injury 1		
Case Number 1	-	MM/DD/YYYY	
	Date of Injury 2	MM/DD/YYYY	-
Case Number 2	D (() ()	MIM/DD/YYYY	
Case Number 3	Date of Injury 3 _	MM/DD/YYYY	-
	Date of Injury 4		
Case Number 4		MM/DD/YYYY	-
Case Number 5	_ Date of Injury 5	MM/DD/YYYY	-
Gass Hamber 6		WWW/DD/TTTT	
njured worker			
First Name		MI	_
Last Name		Suffix	(Jr,Sr,etc)
			•

Occupation (attach description if unclear)

Insurance Claim Number
Date of report(s) to be rated and doctor's name:
MM/DD/YYYY —
MM/DD/YYYY —
MM/DD/YYYY —
This case has been set on for: MM/DD/YYYY for the type of hearing checked below:
Rating MSC
Trial
Conference
Rating requested by:
Name of firm
Representing the
Employee Employer
A copy of this request has been served on
Firm Name
Firm Address 1/PO Box (Please leave blank spaces between numbers, names or words)
Firm Address 2/PO Box (Please leave blank spaces between numbers, names or words)
City State Zip Code