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STATE OF CALIFORNIA
Division of Workers' Compensation
Disability Evaluation Unit

EMPLOYEE'S DISABILITY QUESTIONNAIRE

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	Employer
Social Security No.	Nature of employer's business
Street and Number	
City, State, Zip Code	Claim number
Date of Injury	Date of Birth

PLEASE ANSWER THE FOLLOWING QUESTIONS FULLY, using reverse side if needed:

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?_____

Sign here _____Date: _____

DEU Form 100
(Rev. 06-05)