

**REQUEST FOR SUMMARY RATING DETERMINATION  
of Primary Treating Physician's Report**

State of California  
Division of Workers' Compensation  
Disability Evaluation Unit

DEU Use Only

To be used for injuries which occur on or after January 1, 1994.

**INSTRUCTIONS:**

1. Complete this form and send it to the Disability Evaluation Unit along with a copy of the primary treating physician's report.
2. This form and any attachments including a copy of the primary treating physician's report must be served on the other party.
3. If you receive the completed form from the other party and you disagree with the description of the occupation or earnings, please attach the correct information to a copy of this form and send it to the Disability Evaluation Unit. You must also send a copy of your objection to the other party.

**REQUEST IS MADE BY:**

\_\_\_\_ Employee  
\_\_\_\_ Claims Administrator

**PHYSICIAN:  
EXAM DATE:**

**CLAIMS ADMINISTRATOR**

Company:  
Mailing Address:  
City, State, Zip:  
Claim No.:  
Phone No.:  
Adjustor:

**EMPLOYEE**

Name:  
Mailing Address:  
City, State, Zip:  
Date of Injury:  
Date of Birth:  
Social Security #:  
WCAB Case No. (if any):

**EMPLOYER:** \_\_\_\_\_

**NATURE OF EMPLOYER'S BUSINESS:** \_\_\_\_\_

**JOB TITLE:** \_\_\_\_\_

**DESCRIBE THE GENERAL DUTIES OF THE JOB** (Attach job description or job analysis, if available):  
\_\_\_\_\_  
\_\_\_\_\_

**WEEKLY GROSS EARNINGS:** \$ \_\_\_\_\_ Attach a wage statement/DLSR 5020 if earnings are less than maximum. Include the value of additional advantages provided such as meals, lodging, etc. If earnings are irregular or for less than 30 hours per week, include a detailed description of all earnings of the employee from all sources, including other employers, for one year prior to the date of injury. Benefits will be calculated at MAXIMUM RATE unless a complete and detailed statement of earnings is received.

**PROOF OF SERVICE BY MAIL**

On \_\_\_\_\_ I served a copy of this Request for Summary Rating Determination on  
(date)

\_\_\_\_\_ at \_\_\_\_\_ by placing  
(name of employee or claims administrator) (address)

a true copy enclosed in a sealed envelope with postage fully prepaid, and deposited in the U.S. Mail. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature \_\_\_\_\_