REQUEST FOR CONSULTATIVE RATING

State of California
Division of Workers' Compensation
Disability Evaluation Unit

DEU Use Only

Indicate type of request: ☐ Mail-in ☐ Walk-in

INSTRUCTIONS FOR MAIL-IN'S:

1. Enclose pre-addressed envelopes for yourself and the opposing party.
2. Attach a photocopy of the medical report(s) for which a rating is being requested. Do not send original reports.
3. Send this request to the DEU office serving the WCAB location in which the case has been filed.
4. Serve a copy of this request on the representative for the opposing party.

INSTRUCTIONS FOR WALK-IN'S:

1. Place report(s) to be rated on top of the WCAB file, unless report has been placed into evidence.
2. If report(s) have been placed into evidence, clearly mark them with paper clip or post-it note.
3. If a deposition is to be rated, mark or list the pages to be reviewed by the rated.

Injured worker's name	
WCAB case number(s)	
Occupation (attach description if unclear)	
Date of Injury	
Date of birth	
Social security number	
Insurance claim number	

Date of report(s) to be rated and doctor's name:

__/__/____ _____

__/__/____ _____

__/__/____ _____

This case has been set for: ☐ hearing ☐ conference ☐ msc ☐ rating pre-trial on ___/___/_____

Rating requested by: _____ representing the ☐ employee ☐ employer
name of firm

A copy of this request has been served on _____
name of firm