

SAN FRANCISCO OFFICE  
STATE BUILDING ANNEX  
525 GOLDEN GATE AVENUE

MAILING ADDRESS:  
DISABILITY EVALUATION BUREAU  
P.O. BOX 603  
SAN FRANCISCO, CA 94101-0603

PLEASE SEND TWO COPIES

STATE OF CALIFORNIA  
DEPARTMENT OF INDUSTRIAL RELATIONS  
DIVISION OF INDUSTRIAL ACCIDENTS

LOS ANGELES OFFICE  
LOS ANGELES STATE OFFICE BUILDING  
107 SOUTH BROADWAY  
LOS ANGELES 90012-4578

### REQUEST FOR INFORMAL RATING

By Insurance Carrier or Self-Insurer

To: Disability Evaluation Bureau  
Division of Industrial Accidents

Date:

From:

Address:

Carrier's Claim No.:

Employer:

Employee:

Address:

Social Security Number:

Date of Injury:

Month, Day and Year of Birth:

Age at Injury:

Occupation: (IF OCCUPATION IS NOT CLEARLY DEFINED, ATTACH JOB DESCRIPTION)

Wage or Earning Capacity: \$

Per week/month:

(Including additional advantages) (IF LESS THAN MAXIMUM FOR TEMPORARY OR PERMANENT, ATTACH

COMPLETE AND DETAILED STATEMENT OF EARNING CAPACITY.)

Compensation Rate:

For temporary: \$

For permanent: \$

Last date for which temporary compensation was paid: \_\_\_\_\_ (IF DIFFERENT FROM DOCTOR'S

RELEASE DATE OR DATE

SHOWN ON DIA FORM 200,

PLEASE EXPLAIN)

If rehabilitation under L.C. 139.5 is involved:

(a) Is employee presently receiving rehabilitation benefits, including vocational rehabilitation temporary disability? \_\_\_\_\_

(b) If vocational rehabilitation services are concluded, last date for which temporary disability was paid was \_\_\_\_\_

We attach our complete medical file.

By \_\_\_\_\_

Telephone No. \_\_\_\_\_