



State of California
Division of Workers' Compensation
Disability Evaluation Unit



REQUEST FOR CONSULTATIVE RATING

DEU Use Only

Indicate type of request:

Mail-in

Walk-in

INSTRUCTIONS FOR MAIL-IN'S:

1. Attach a photocopy of the medical report(s) for which a rating is being requested, if not previously on file. Do not send original reports.
2. Serve a copy of this request on the representative for the opposing party

INSTRUCTIONS FOR WALK-IN'S:

1. Attach this request form to copies of the medical reports that you wish to have rated.
2. List below the doctor's names and dates of reports to be rated.
3. If a deposition is to be rated, mark or list the pages to be reviewed by the rater.

_____	Date of Birth	_____
SSN (Numbers Only)		MM/DD/YYYY

_____	Date of Injury 1	_____
Case Number 1		MM/DD/YYYY

_____	Date of Injury 2	_____
Case Number 2		MM/DD/YYYY

_____	Date of Injury 3	_____
Case Number 3		MM/DD/YYYY

_____	Date of Injury 4	_____
Case Number 4		MM/DD/YYYY

_____	Date of Injury 5	_____
Case Number 5		MM/DD/YYYY

Injured worker

_____	MI
First Name	

_____	Suffix(Jr,Sr,etc)
Last Name	

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: _____ for the type of hearing checked below:

MM/DD/YYYY

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