

STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT
MAILING ADDRESS:
P. O. Box 71010
Oakland, CA 94612
(510) 286-3700 or (800) 794-6900 Fax: (510) 622-3467

QME APPOINTMENT NOTIFICATION FORM

To the Qualified Medical Evaluator: You are required by law to give notice on this form when an appointment has been made with you to perform a QME comprehensive medical evaluation. Please complete this form in its entirety. You are legally required to include: the name and address of the employee, the name of the employer and claims administrator, and the appointment time and date.

EMPLOYEE INFORMATION

NAME:
ADDRESS:
PHONE:
DATE OF INJURY:
PANEL No.:
CLAIM/CASE No.:

EMPLOYER INFORMATION

NAME:
ADDRESS:
PHONE:

CLAIMS ADMINISTRATOR INFORMATION

NAME:
COMPANY:
ADDRESS:
PHONE:

APPOINTMENT INFORMATION

DATE OF APPOINTMENT CALL:
DATE OF APPOINTMENT:
TIME OF APPOINTMENT:
LOCATION OF APPOINTMENT: 3798 JAMES ROAD SUITE 9 ARCATA, CA 95521
CERTIFIED INTERPRETER REQUIRED: (LANGUAGE)

COPY TO: [X] EMPLOYEE (and employee's attorney, if known)
[X] CLAIMS ADMINISTRATOR (and attorney, if known)

SIGNATURE OF QME: [Signature]
QME NAME (print/type): Jonathan Rutchik, M.D., M.P.H
ADDRESS AND PHONE: 20 Sunnyside Ave Suite A-321 Mill Valley, Ca 94941 (415) 381-3133

Note to Claims Administrator: The Administrative Director's regulation 10160 requires you to forward a completed, DWC-AD form 101 (DEU) (Request for Summary Rating Determination of Qualified Medical Evaluator's Report) (see, 8 Cal. Code Regs. § 10160 and 10161) together with all medical reports and medical records prior to the scheduled examination with the QME.

* ALL RECORDS TO BE SENT TO 20 SUNNYSIDE AVE. STE A-321 MILL VALLEY CA 94941