



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.

SSN (Numbers Only)	Date of Birth	MM/DD/YYYY
Case Number 1	Date of Injury 1	MM/DD/YYYY
Case Number 2	Date of Injury 2	MM/DD/YYYY
Case Number 3	Date of Injury 3	MM/DD/YYYY
Case Number 4	Date of Injury 4	MM/DD/YYYY
Case Number 5	Date of Injury 5	MM/DD/YYYY

Injured worker

First Name

MI

Last Name

Suffix(Jr,Sr,etc)

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