

STATE OF CALIFORNIA  
**Division of Workers' Compensation – Medical Unit**  
P.O. Box 71010, Oakland, CA 94612  
(510) 286-3700 or (800) 794-6900

**QUALIFIED ~~OR AGREED~~ MEDICAL EVALUATOR'S FINDINGS SUMMARY FORM**  
**UNREPRESENTED INJURED EMPLOYEE CASES ONLY**

**EMPLOYEE**

1. Employee Name (First, Middle, Last) \_\_\_\_\_ 2. Social Sec. No. (Optional) \_\_\_\_\_ 3. Date of Injury \_\_\_\_\_  
4. Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ 5. Phone \_\_\_\_\_

**CLAIMS ADMINISTRATOR/EMPLOYER** (if none, enter Employer information)

6. Name \_\_\_\_\_  
7. Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ 8. Phone \_\_\_\_\_

**EVENT DATES**

9. Date of Appointment Call \_\_\_\_\_ 10. Initial Examination Date \_\_\_\_\_ 11. Date of Referral for Medical Testing/Consultation \_\_\_\_\_  
12. Date ~~AME/QME's~~ Report Served on all Parties \_\_\_\_\_

**DISPUTED MEDICAL ISSUES AND CONCLUSIONS**

13. The following medical issues will be used to determine the ~~patient's~~ **injured employee's** eligibility for workers' compensation **benefits**.

(Check the appropriate box)

Yes No Pending or Info. Not Sent

- |  |  |                              |                          |
|--|--|------------------------------|--------------------------|
| a. Has the condition reached permanent and stationary status or maximum medical improvement? | <input type="checkbox"/>                                 | <input type="checkbox"/>     | <input type="checkbox"/> |
| b. Is there permanent impairment/disability?   | <input type="checkbox"/>                                 | <input type="checkbox"/>     | <input type="checkbox"/> |
| c. Did work cause or contribute to the injury or illness?                                    | <input type="checkbox"/>                                 | <input type="checkbox"/>     | <input type="checkbox"/> |
| d. If permanent disability exists, is apportionment warranted?                               | <input type="checkbox"/>                                 | <input type="checkbox"/>     | <input type="checkbox"/> |
| e. Is there a need for current or future medical care?                                       | <input type="checkbox"/>                                 | <input type="checkbox"/>     | <input type="checkbox"/> |
| f. Can this employee now return to his/her usual job?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |                          |
| If yes:  |  |                              |                          |
| i. Without restrictions  | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No, | If YES, Date: _____      |
| ii. With restrictions  | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No, | If YES, Date: _____      |

**BASIS FOR CONCLUSIONS**

(Check the appropriate box)

Yes No Pending or Info. Not Sent

- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
| 14. Are there subjective complaints?                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Are there any abnormal physical or psychological examination findings? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Are impairments described and measured using the AMA Guides?           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. If the AMA Guides are used, are percentages of impairment stated?      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Are there any relevant diagnostic test results (x-ray/laboratory)?     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- |   | Yes                      | No                       | Pending or<br>Info. Not Sent |
|---|--------------------------|--------------------------|------------------------------|
| 19. What are the diagnoses? (List) _____  |                          |                          |                              |
| 20. Were medical records reviewed?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>     |
| 21. Were other physicians consulted?  | <input type="checkbox"/> | <input type="checkbox"/> |                              |
| <b><u>22. Are there any unresolved disputed issues beyond the scope of your licensure or clinical competence that should be addressed by an evaluator in a different specialty?</u></b> | <input type="checkbox"/> | <input type="checkbox"/> |                              |
| <b><u>23. If the answer to # 22 is yes, what disputed issue(s)?</u></b> _____   |                          |                          |                              |
| <b><u>24. Based on the answer in # 23, what specialty (or specialties)?</u></b> _____   |                          |                          |                              |

**QME**

22. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

23. Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

24. Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

25. Phone: \_\_\_\_\_ Cal. License No.: \_\_\_\_\_

**Declaration of Service of Medical Legal Report (Lab. Code § 4062.3(i))**

I, \_\_\_\_\_, declare under penalty of perjury under the laws of the State of California that:

*(Print Name)*

1. I am over the age of 18 and am employed by \_\_\_\_\_.

*(Name of Employer)*

2. On \_\_\_\_\_, I served this QME or AME Summary Form with the attached medical-

*(Date)*

legal report on each of the persons/firms named below, and by using the means of service, indicated below. I further declare that I am readily familiar with the practice of this office, named in (1), above, for collection and processing of correspondence for mailing, which is to deposit envelopes with the U.S. Postal Service on that same day with postage fully prepaid thereon at \_\_\_\_\_ in the ordinary course of business.

*(City) (State)*

I further declare that for service by mail, I either deposited this document personally in the U.S. Mail, or that I placed it for normal collection with the office stated in (1) above, in time for collection and processing that same day.

*For service by messenger delivery:* I further declare that I am familiar with the practice of the office stated in (1), above for messenger delivery, and I caused this document to be placed in a sealed envelope and to be delivered to a courier employed by \_\_\_\_\_ for personal delivery of each such envelope to the addressee, within two working business days, at the address and on the date indicated in below:

Means of service: \_\_\_\_\_ Date: \_\_\_\_\_ Addressee and Address: \_\_\_\_\_  
(e.g. U.S. mail; Certified mail; Overnight mail; courier)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ *Disability Evaluation Unit, DWC,*  
\_\_\_\_\_  
\_\_\_\_\_

**If appropriate:** \_\_\_\_\_ *Medical Director, DWC Medical Unit, P.O. Box 71010, Oakland, CA 94612*

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, in the county of \_\_\_\_\_, \_\_\_\_\_

*(State)*

\_\_\_\_\_  
\_\_\_\_\_ *(Signature of Declarant)* \_\_\_\_\_ *(Print Name)*

**Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))**

I, \_\_\_\_\_, declare:  
(Print Name)

1. I am over the age of 18 and I am not a party to this case.

2. My business address is : \_\_\_\_\_

3. On the date shown below, I served this QME Findings Summary Form with the original, or a true and correct copy of the original, comprehensive medical-legal report, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

- A            depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.
- B            placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.
- C            placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.
- D            placing the sealed envelope for pick up by a professional messenger service for service. (*Messenger must return to you a completed declaration of personal service.*)
- E            personally delivering the sealed envelope to the person or firm named below at the address shown below.

Means of service:  
(For each addressee,  
Enter A – E as appropriate)

Date:                      Addressee and Address:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

When report addresses PD:

Disability Evaluation Unit, DWC,

**I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.**

Date Signed: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Declarant)

\_\_\_\_\_  
(Print Name)



## INSTRUCTIONS FOR QME FORM 111

### USE THIS FORM ONLY WHEN THE INJURED EMPLOYEE IS UNREPRESENTED

To the QME ~~or AME~~: You are required by Labor Code section 4062.3(i) to summarize the medical findings from your comprehensive medical-legal evaluation on the form prescribed by the Administrative Director. Please complete the form in its entirety.

Employee Information: Fill in the employee's full name, address, telephone number and date of injury.

Event Dates: Complete dates that patient called for an appointment, date of initial examination, date referred for consultation(s), if any, and date report served on all parties. Supplying these dates is a legal requirement.

Disputed Medical Issues and Conclusions: Complete this section by checking appropriate box and stating what page(s) or section of the medical legal report contain the narrative for details. If diagnostic or laboratory tests have been ordered and the results or a medical records request is pending, check that box. If you cannot render opinions because of pending information, please complete and serve the report to comply with the 30-day time requirement and state what issues could not be evaluated.

Basis for Conclusions: Check appropriate box and give page numbers or section where the narrative in the full report is found. For diagnoses, in addition to page numbers, please briefly summarize the diagnoses in lay terms where possible. Also, list the name and specialty for other physicians who provided information used in the medical legal report.

**Need for Additional Evaluation in Another Specialty: Labor Code section 4062.3 directs each evaluator to address all contested medical issues arising from all injuries reported on one or more claim forms prior to the evaluator's initial evaluation. Each evaluator is expected to address permanent impairment consistent with the AMA guides for the evaluator's specialty. In the event there are contested medical issues outside of the scope of your licensure or clinical competence that require evaluation by a physician in a different specialty, complete the information required in questions 22 through 24, and serve a copy of your report on the Medical Unit of DWC.**

QME Signature: Remember under the Labor Code, all your reports must be signed under the penalty of perjury. You are required to serve the medical legal report and this form on the employee, the claims administrator (if none, the employer) and **whenever the report finds permanent impairment and permanent disability, on** the Disability Evaluation Unit (DEU) having jurisdiction over the employee's area of residence.

Declaration of Service of Medical – Legal reports: Labor Code sections 139.2(j)(1)(A) and 4062.3 (i) and section 38 of Title 8 of the California Code of Regulations require the QME ~~or AME~~ to serve the medical-legal report and this form **on the claims administrator, or if none the** employer, ~~(or employer's claims administrator)~~ and the injured worker within 30 days from the commencement of the examination, unless certain conditions are met. Please complete the proof of service to show the date the report was served on the parties **and the Disability Evaluation Unit.**