

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

(date)

NOTICE OF DENIAL OF REQUEST FOR TIME EXTENSION

(Injured Employee or Attorney)
(address)

(Claims ~~Adjuster/Employer~~ Administrator or Attorney)
(address)

Re: (Injured Employee name) v. (Employer/Insurer name)

Claim No. _____

QME Panel No.: _____

Name of QME/AME: _____

Evaluation Date (or Date of Request for Supplemental Report): _____

The request by the evaluator named above for an extension of time to complete a medical-legal evaluation report has been **denied** by the Medical Director of the Division of Workers' Compensation. The parties have two options: 1) you may wait for the report if both parties agree in writing to waive the lateness of the report; or 2) if either party does not agree to wait, you may agree on a new AME (represented cases only) or request a replacement panel QME. If you are represented by an attorney, consult your attorney.

Please advise the Medical Unit and the evaluator **within fifteen (15) days** of the date of this letter what you wish to do. Sign the form below, mail or fax it to the **Medical Unit at PO Box 71010, Oakland, CA 94612 (or fax (510) 622-3467)**, and send a copy to the evaluator. If you have any questions, please call the Medical Unit at (510) 286-3700 or 1-800-794-6900.

(Check one)

I wish to waive the lateness of this report and accept the report when it is done.

I request a new QME ~~panel~~ due to the lateness of the original QME or AME report. [For Attached represented cases only, is attach a copy of my the first written proposal for one or more physicians to be an AME.]

Employee (or Attorney) Signature

(Print name also)

Date

~~Adjuster/Employer~~ Claims Administrator (or Attorney) Signature

(Print name also)

Date

cc: QME or AME

FOR DWC USE ONLY

Original panel source _____ Original panel specialty _____ Referral _____