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

OME 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. The Administrative Director also requires that you serve this appointment notification form on the employee and the claims administrator, or if none the employer, and their attorneys in a represented case, if known, within five (5) business days after having scheduled the injured worker to be seen for a QME comprehensive medical evaluation. You also must use this form if you refer the injured worker for a consultation to advise the parties of the date and time of the appointment with the consulting physician (See, & Cal. Code Regs. § 32). You may not cancel the appointment less than six (6) calendar days prior to the appointment date, except for good cause (See, & Cal. Code Regs. § 34). If you reschedule an appointment, review regulation 34 and the ethical rules in regulation 41 (See, 8 Cal Code Regs. §§ 34 and 41(a)(7) and (a)(8)).

EMPLOYEE INFORMATION

NAME:					
ADDRESS:					
	City		State	Zip	
PHONE:		SOCIAL S	ECURITY No.:	er is for record-keeping purposes only.)	
DATE OF INITION.			(Social Security Number is for record-keeping purposes only.) ———————————————————————————————————		
DATE OF INJUNT:	PAN	SE NU.:	CLAIIVICASE	190,,	
		EMPLOYER INFOR	MATION		
NAME:					
ADDRESS:					
	City		State	Zip	
PHONE:					
	CI AIM	C ADMINISTRATOR	NEODMATION		
	CLAIM	S ADMINISTRATOR	TINFORMATION		
NAME:					
COMPANY:					
ADDRESS:					
PHONE:	City		State	Zip	
		PPOINTMENT INFO	<u>PRMATION</u>		
D LTD OD		DATE OF	TO	E OF	
DATE OF APPOINTMENT CALL		DATE OF APPOINTMENT	APPOI	TIME OFAPPOINTMEN'T	
LOCATION OF APPOINTMEN	т. 650 Н	owe Ave, Suite 830	Sacramento, Ca 958	25	
CERTIFIED INTERPRETER REC					
COPY TO:					
	\mathbf{Z}	CLAIMS ADMINISTRATOR (and attorney, if known)			
SIGNATURE OF QME:					
QME NAME (print/type): Jon	athan Ri	ıtchik, MD, MPH			
ADDRESS AND PHONE; 20 Su			l VAlley, Ca 94941 ((415)381-3133	
Note to Claims Administrator: The					
101(DELD/Request for Summary Ratio					

together with all medical reports and medical records prior to the scheduled examination with the QME. You must also provide the employee with a DWC-AD form 100 (DEU) (Employee's Disability Questionnaire) (See, 8 Cal. Code Regs. §§ 10160 and 10161) prior to the examination.

ALL RECORDS TO BE SENT TO 20 SUNNYSIDE AVE STEA-321 MILL VALLEY, CA 94941