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, 8 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, 8 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	SECURITY No.:		
DATE OF BUT INV.	(Social Security Number is for record-keeping purposes only.) PANEL No.: CLAIM/CASE No.:			
DATE OF INJURY:	PANEL No.:	CLAIM/CASE	No.:	
	EMPLOYER INFO	<u>PRMATION</u>		
NAME:				
ADDRESS:				
•	City	State	Zip	
PHONE:		•		
	CLAIMS ADMINISTRATO	OR INFORMATION		
NAME:				
COMPANY:	·			
ADDRESS:				
PHONE:	City	State	Zip	
	APPOINTMENT IN	ORMATION		
DATE OF	DATE OF	TIM	TIME OF	
APPOINTMENT CALL	APPOINTMENT_	APPO	APPOINTMENT	
LOCATION OF APPOINTMEN	_{IT:} 3798 JANES ROAD SU	ITE 9 ARCATA, CA	95521	
CERTIFIED INTERPRETER REC	QUIRED: (LANGUAGE)	-		
COPY TO:	EMPLOYEE (and employee's attorney, if known)			
	Cfaims admini	STRATOR (and attorney, if k	nown)	
SIGNATURE OF QME:	Mule			
QME NAME (print/type): Jon	athan Rutchik, M.D., M.P.	H		
ADDRESS AND PHONE; 20 Su	nnyside Ave Suite A-321 M	iill Valley, Ca 94941	416.)381-3133	
Note to Claims Administrator: The	Administrative Director's regulation	1 10160 requires you to for	vard a completed, DWC-AD form	

QME Form 110 (rev. February 2009)

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.