STATE OF CALIFORNIA
Department of Industrial Relations
Division of Workers' Compensation
DISABILITY EVALUATION UNIT

Date: ____________________

TO: Presiding Workers' Comp. Judge, ______________________________________
(Office)

FROM: Disability Evaluation Unit, ____
(Office)

SUBJECT: DEU File:
Employee:
QME:
Date of Report:

The attached formal medical evaluation report indicates that part or all of the permanent disability may be subject to apportionment pursuant to Labor Code Section 4663 and/or Labor Code Section 4664. Please determine whether the apportionment is inconsistent with the law.

If you believe the apportionment is inconsistent with the law, you may refer the report back to the medical evaluator for correction or clarification. If you receive no response from the medical evaluator within 30 days from your request, please make your determination based on the original report.

After checking the appropriate space, sign and date the bottom of this form and return it with the medical report to the DEU office listed above.

Thank you.

The apportionment: IS CONSISTENT ________ or
IS NOT CONSISTENT ________ with the law.

______________________________________, **Workers' Compensation Judge**
(Signature)

____
(Date)

NOTE: This memorandum is an administrative document and is not admissible in any judicial proceeding.