

State of California
DIVISION OF WORKERS' COMPENSATION – MEDICAL UNIT
ADDITIONAL PANEL REQUEST
TITLE 8, CALIFORNIA CODE OF REGULATIONS § 31.7
(Please print or type)

*If anything has changed including parties, addresses, and represented status,
Please attach the information on a separate sheet of paper*

Date of Request:
(Required)

Original Panel Number: *(Required)*

Requesting Party: *(Check one box only)*

- Applicant's Attorney/Injured Worker
- Defense Attorney/Claims Administrator
- Joint Request

Claim Number: *(Required)*

Injured Worker: *(Required)*

First Name

Last Name

Specialty (ies): *(Required)* **(Use the three-letter code)**

Reason for Additional Panel (all references are to Title 8, CCR 31.7 unless otherwise noted):

- Judge's Order (Please attach a copy of the order). (b)(1)
- The AME or QME selected advised the parties and Medical Director there are issues which need to be addressed that are outside his or her clinical competence. (Please attach copy of AME/QME report) (b)(2)
- A written agreement between the parties in a represented case. (Please attach a signed joint letter or jointly sign the bottom of this form) (b)(3)
- Agreement of the parties and an Information and Assistance Officer in an unrepresented case. (Please attach I&A recommendation or have I&A Officer sign on the line below) (b)(4)

Name of Requestor (Print)

Requestor's Signature

Name of Requestor (Print)

Requestor's Signature

Name of I&A Officer (Print)

I&A Officer's Signature