STATE OF CALIFORNIA
Division of Workers' Compensation – Medical Unit
P.O. Box 71010, Oakland, CA 94612
(510) 286-3700 or (800) 794-6900

QUALIFIED MEDICAL EVALUATOR'S FINDINGS SUMMARY FORM

UNREPRESENTED INJURED EMPLOYEE CASES ONLY

EMPLOYEE

1. Employee Name (First, Middle, Last) | 2. Social Sec. No. (Optional) | 3. Date of Injury

4. Street Address | City | Zip | 5. Phone

CLAIMS ADMINISTRATOR *(if none, enter Employer information)*

6. Name

7. Street Address | City | Zip | 8. Phone

EVENT DATES

9. Date of Appointment Call | 10. Initial Examination Date | 11. Date of Referral for Medical Testing/Consultation

12a. Date QME Report Served on all Parties | 12b. Date(s) of all prior report(s) served by this QME?

DISPUTED MEDICAL ISSUES AND CONCLUSIONS

13. The following medical issues will be used to determine the injured employee's eligibility for workers' compensation benefits.

(*Check the appropriate box)*

	Yes	No	Pending or Info. Not Sent
a. Has the condition reached permanent and stationary status or maximum medical improvement?	☐	☐	☐
b. Is there permanent impairment/disability?	☐	☐	☐
c. Did work cause or contribute to the injury or illness?	☐	☐	☐
d. If permanent disability exists, is apportionment warranted?	☐	☐	☐
e. Is there a need for current or future medical care?	☐	☐	☐

f. Can this employee now return to his/her usual job? ☐Yes ☐No

If yes:

i. Without restrictions ☐Yes ☐No, If YES, Date: _____

ii. With restrictions ☐Yes ☐No, If YES, Date: _____

BASIS FOR CONCLUSIONS

(*Check the appropriate box)*

	Yes	No	Pending or Info. Not Sent
14. Are there subjective complaints?	☐	☐	☐
15. Are there any abnormal physical or psychological examination findings?	☐	☐	☐
16. Are impairments described and measured using:			
(For non-psyche injuries) the AMA Guides?	☐	☐	☐
(For psyche injuries) the GAF and 2005 PD Schedule?	☐	☐	☐

	Yes	No	Pending or Info. Not Sent
17. If the AMA Guides are used, are percentages of impairment stated?	☐	☐	☐
18. Are there any relevant diagnostic test results (x-ray/laboratory)?	☐	☐	☐
19. What are the diagnoses? (List) _____			
20. Were medical records reviewed?	☐	☐	☐
21. Were other physicians consulted?	☐	☐	
22. Are there any unresolved disputed issues beyond the scope of your licensure or clinical competence that should be addressed by an evaluator in a different specialty?	☐	☐	

23. If the answer to # 22 is yes, what disputed issue(s)?_____

24. Based on the answer in # 23, what specialty (or specialties)?_____

QME

22. Signature:_____Date:_____

23. Name:_____Specialty:_____

24. Street Address:_____City:_____Zip:_____

25. Phone:_____ Cal. License No.:_____

Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))

I, _____, declare:
(Print Name)

1. I am over the age of 18 and I am not a party to this case.
2. My business address is :_____

3. On the date shown below, I served this QME Findings Summary Form with the original, or a true and correct copy of the original, comprehensive medical-legal report, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

A depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.

B placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.

C placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.

D placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*

E personally delivering the sealed envelope to the person or firm named below at the address shown below.

Means of service: *(For each addressee, Enter A – E as appropriate)*	Date:	Addressee and Address:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

When report addresses PD:

_____ _____ Disability Evaluation Unit, DWC, _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date Signed: _____

_____ _____

(*Signature of Declarant*) (*Print Name*)

INSTRUCTIONS FOR QME FORM 111

USE THIS FORM ONLY WHEN THE INJURED EMPLOYEE IS UNREPRESENTED

To the QME: You are required by Labor Code section 4062.3(i) to summarize the medical findings from your comprehensive medical-legal evaluation on the form prescribed by the Administrative Director. Please complete the form in its entirety.

Employee Information: Fill in the employee's full name, address, telephone number and date of injury.

Event Dates: Complete dates that patient called for an appointment, date of initial examination, date referred for consultation(s), if any, and date(s) report(s) served on all parties. Supplying these dates is a legal requirement.

Disputed Medical Issues and Conclusions: Complete this section by checking appropriate box and stating what page(s) or section of the medical legal report contain the narrative for details. If diagnostic or laboratory tests have been ordered and the results or a medical records request is pending, check that box. If you cannot render opinions because of pending information, please complete and serve the report to comply with the 30-day time requirement and state what issues could not be evaluated.

Basis for Conclusions: Check appropriate box for each question on form. For diagnoses, please briefly summarize the diagnoses in lay terms where possible, except when you deem that not advisable in disputed claims involving injury to the psyche. Also, list the name and specialty for other physicians who provided information used in the medical legal report.

Need for Additional Evaluation in Another Specialty: Labor Code section 4062.3 directs each evaluator to address all contested medical issues arising from all injuries reported on one or more claim forms prior to the evaluator's initial evaluation. Each evaluator is expected to address permanent impairment consistent with the AMA guides for the evaluator's specialty, or for disputed injuries to the psyche consistent with the global assessment of functioning (GAF) as directed in the 2005 Permanent Disability Schedule adopted by the Administrative Director effective 1/1/2005. In the event there are contested medical issues outside of the scope

of your licensure or clinical competence that require evaluation by a physician in a different specialty, complete the information required in questions 22 through 24, and serve a copy of your report on the Medical Unit of DWC.

QME Signature: Remember under the Labor Code, all your reports must be signed under the penalty of perjury. You are required to serve the medical legal report and this form on the employee (unless the claim involves a disputed injury to the psyche and section 36.5 of Title 8 of the California Code of Regulations applies and provides for a different method of service), the claims administrator (if none, the employer) and whenever the report finds permanent impairment and permanent disability, on the Disability Evaluation Unit (DEU) having jurisdiction over the employee's area of residence.

Declaration of Service of Medical – Legal reports: Labor Code sections 139.2(j)(1)(A) and 4062.3 (i) and section 38 of Title 8 of the California Code of Regulations require the QME to serve the medical-legal report and this form on the claims administrator, or if none the employer, and the injured worker (except when section 36.5 of Title 8 of the California Code of Regulations applies) within 30 days from the commencement of the examination, unless certain conditions are met. Please complete the proof of service to show the date the report was served on the parties and the Disability Evaluation Unit.