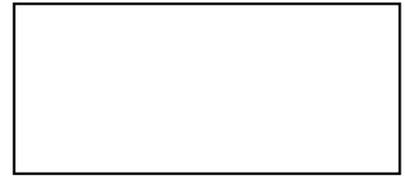




**STATE OF CALIFORNIA  
Division of Workers' Compensation  
Disability Evaluation Unit**



DEU Use Only

**EMPLOYEE'S DISABILITY QUESTIONNAIRE**

This form will aid the doctor in determining your permanent impairment or disability. Please complete this form and give it to the physician who will be performing the evaluation. The doctor will include this form with his or her report and submit it to the Disability Evaluation Unit, with a copy to you and your claims administrator.

**Employee**

\_\_\_\_\_  
First Name

\_\_\_\_\_  
MI

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
SSN (Numbers Only)

\_\_\_\_\_  
Address1/PO Box (Please leave blank spaces between numbers, names or words)

\_\_\_\_\_  
Address2/PO Box (Please leave blank spaces between numbers, names or words)

\_\_\_\_\_  
International Address (Please leave blank spaces between numbers, names or words)

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

Date of Birth \_\_\_\_\_  
MM/DD/YYYY

Date of Injury \_\_\_\_\_  
MM/DD/YYYY

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Nature of Employer's Business

\_\_\_\_\_  
Claim Number 1

Claim Number 2 \_\_\_\_\_

Claim Number 3 \_\_\_\_\_

Claim Number 4 \_\_\_\_\_

Claim Number 5 \_\_\_\_\_

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**PLEASE ANSWER THE FOLLOWING QUESTIONS FULLY:**

How was your evaluating doctor selected? (check one)

From a list of doctors provided by the State of California, Division of Workers' Compensation.

Other (explain) \_\_\_\_\_

What is the name of the doctor who will be doing the evaluation? \_\_\_\_\_

When is your examination scheduled? \_\_\_\_\_

What were your job duties at the time of your injury? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What is the disability resulting from your injury? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How does this injury affect you in your work? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever had a disability as a result of another injury or illness? \_\_\_\_\_

If so, when? \_\_\_\_\_

Please describe the disability? \_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_  
MM/DD/YYYY