REQUEST FOR RECONSIDERATION OF SUMMARY RATING BY THE ADMINISTRATIVE DIRECTOR

This form may be used by an unrepresented employee or his or her employer to request that the Administrative Director determine whether a permanent disability rating issued by the Disability Evaluation Unit should be reconsidered pursuant to Labor Code section 4061(g).

A request for reconsideration may be granted if it is shown that the Qualified Medical Evaluator (QME) or Treating Physician (TP) has failed to address all issues, failed to completely address issues, failed to follow the procedures promulgated by the DWC Medical Unit, or if the rating was incorrectly calculated.
This procedure is applicable only to injuries occurring on or after 1/1/91. Please verify that you sent a copy of this request to the other party (employee or claims administrator) by filling out the proof of service below after reading the instructions on the reverse side.

This request must be submitted within thirty (30) days of receipt of the rating.

SEND TO: Administrative Director
Division of Workers' Compensation
Attn: Summary Rating Reconsideration
P.O. Box 420603
San Francisco, CA 94142

INCLUDE: (1)This **completed form**;
(2)Other information supporting the request.

Employee

First Name _____ MI _____

Last Name _____

Address 1/PO Box (Please leave blank spaces between numbers, names or words) _____

Address 2/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 _____

Employer / Adjusting Agency

Name _____

Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Disability Evaluation Unit File Number

Claim Number

SSN (Numbers Only)

Date of Injury _____
MM/DD/YYYY

REASON(S) FOR REQUEST: *(Check reason and explain below. Attach additional sheets if necessary.)*

☐ QME/TP failed to address all issues

☐ QME/TP failed to completely address issues

☐ IMC Medical Unit procedures not followed by QME/TP

☐ Rating was incorrectly calculated

Explanation: _____

Reconsideration of Summary Rating is being requested by:

☐ Injured worker

☐ Employer/Adjusting Agency

Name

PROOF OF SERVICE BY MAIL (Instructions on Reverse)

On _____, I served a copy of this Request for Summary Rating Determination on

Name of Employee _____

Address _____

City _____ State _____ Zip _____

by placing a true copy enclosed in a sealed envelope with postage fully prepaid, and deposited in the U.S. Mail. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____
Signature

INSTRUCTIONS FOR COMPLETING THE PROOF OF SERVICE BY MAIL

Complete the Proof of Service By Mail on the reverse side as follows:

PROOF OF SERVICE BY MAIL (**SAMPLE)**

1

On _____ I served a copy of this Request for Reconsideration of Summary Rating on
MM/DD/YYYY

_____ # 2
(name of employee or claims administrator)

_____ # 3
Address/PO Box (Please leave blank spaces between numbers, names or words)

_____ _____ _____
City State Zip Code

by placing a true copy enclosed in a sealed envelope with postage fully prepaid, and deposited in the U.S. Mail. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature _____ # 4

1) List on line #1 the date on which you mailed this form.

2) If you are the Injured Employee, list on line #2 the name of the Insurance Carrier or Claims Adjusting Agency handling your case. If you are the Insurance Carrier/Claims Adjusting Agency, list the name of the Injured Employee.

3) List on line #3 the mailing address for the Insurance Carrier/Claims Adjusting Agency or Injured Employee you listed on line #2.

4) Sign your name on line #4.