

## State of California Division of Workers' Compensation Disability Evaluation Unit

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## REQUEST FOR SUMMARY RATING DETERMINATION of Primary Treating Physician Report

**DEU Use Only** 

To be used for injuries which occur on or after January 1, 1994.

## **INSTRUCTIONS:**

- 1. Complete this form and send it to the Disability Evaluation Unit along with a copy of the primary treating physician's report.
- 2. This form and any attachments including a copy of the primary treating physician's report must be served on the other party .
- 3. If you receive the completed form from the other party and you disagree with the description of the occupation or earnings, please attach the correct information to a copy of this form and send it to the Disability Evaluation Unit. You must also send a copy of your objection to the other party.

REQUEST IS MADE BY: Employee Claims Administrator		
PHYSICIAN		
EXAM DATE		
Claims Administrator Information (if known and if applicable)		
Name (Please leave blank spaces between numbers, names or words)		
Street Address 1/PO Box (Please leave blank spaces between numbers, names or words)		
Street Address 2/PO Box (Please leave blank spaces between numbers, names or words)		_
City	State	Zip Code
Claim No.		
Phone Number		
Adjustor		
DWC-AD form102 (DEU) (11/2008)		DFU102

Employee		
Mr. Ms. Mrs.		+
First Name	MI	l
Last Name		
Street Address 1/PO Box (Please leave blank spaces between numbers, names or w	ords)	
Street Address 2/PO Box (Please leave blank spaces between numbers, names or w	ords)	
International Address (Please leave blank spaces between numbers, names or words	3)	
City	State	Zip Code
Date of Injury		
Date of Birth		
SSN (Numbers Only)		
Case No.		
Employer		
Nature of Employers Business		
Job Title		
DESCRIBE THE GENERAL DUTIES OF THE JOB (Attach job description or job ana	lysis, if available	):
WEEKLY GROSS EARNINGS: \$ Attach a wag	ge statement/DLS	SR 5020 if earnings

weekly Gross Earnings: \$\_\_\_\_\_\_. Attach a wage statement/DLSR 5020 if earnings are less than maximum. Include the value of additional advantages provided such as meals, lodging, etc. If earnings are irregular or for less than 30 hours per week, include a detailed description of all earnings of the employee from all sources, including other employers, for one year prior to the date of injury. Benefits will be calculated at MAXIMUM RATE unless a complete and detailed statement of earnings is received.

DWC-AD form102 (DEU) (11/2008)

## **PROOF OF SERVICE BY MAIL**

On	, I served a copy of this Request for Summary Rating Determination on					
Name of Employee						
Address						
City		State	Zip Code			
nder penalty of perj	ury under the laws of the State	e of California that the foregoing is	true and correct.			

DEU102