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State of California
Division of Workers' Compensation
Disability Evaluation Unit

DEU Use Only

REQUEST FOR SUMMARY RATING DETERMINATION of Primary Treating Physician Report

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 _____
MM/DD/YYYY

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

Employee

☐ Mr. ☐ Ms. ☐ Mrs.

First Name _____ MI _____

Last Name _____

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) _____

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

City _____ State _____ Zip Code _____

Date of Injury _____
MM/DD/YYYY

Date of Birth _____
MM/DD/YYYY

SSN (Numbers Only) _____

Case No. _____

Employer _____

Nature of Employers Business _____

Job Title _____

DESCRIBE THE GENERAL DUTIES OF THE JOB (Attach job description or job analysis, if available):

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.

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 _____

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