RATING REQUEST

FROM:
_____
_____
_____

APPLICANT INFORMATION	**WCAB #:**
Name:	Date of Birth:
Employer: ☐ Company has more than 50 employees	*SSN#:*
Occupation: Occupation Group #:	Date of Injury:
Gross Salary: ☐ Weekly ☐ Bi-Monthly ☐ Monthly	Job Offer Date:
Report:	P&S Date:

EVALUATOR INFORMATION	
Evaluator:	Report Date:
Requested By:	Request Date:
Requestor Phone: Fax:	eMail:

☐	**INCLUDE OGILVIE RATING**
	Occupation from EDD Website: ☐ Applicant Currently Working ☐ Applicant *NOT* Working - Last Day Worked:
	Avg. Weekly Hours: Total Income for Last 3 Years:
	Report:

RATING INFORMATION	
	MDIS Control #:
Rating Completed By:	**Date Completed:**

CHECKLIST	
☐ Faxed this form.	☐ Faxed copy of medical report to be rated.

Mail, Fax or eMail this Request Form to:
527 E. Rowland Street · Suite 215 · Covina, CA 91723 · **Attn: RATING REQUEST**
Tel: (800) 737-8840 · Fax: (800) 975-1653
e/Mail: mdisorders@gmail.com