Print Form

Qualified Medical Evaluator Complaint Form

Department of Industrial Relations
Division of Workers' Compensation - Medical Unit
P. O. Box 71010
Oakland, CA 94612

Instructions for Completing this Complaint Form

1. Legibly print or type all information.

2. Provide the name of the Qualified Medical Evaluator and the date of the evaluation.

3. Provide the address where the evaluation was performed.

4. If you are complaining about the contents of the report or the way the evaluation was conducted, please include the medical report of the QME, if available.

5. Please sign and date the complaint form.

NOTICE: Except for the name of the physician, the remainder of the information requested is voluntary; however, the failure to provide the requested information may delay or prevent the investigation of your complaint. Please provide as much information as possible in your complaint. The Division of Workers' Compensation will use the information in your complaint in part to determine whether a violation of state law has occurred. If a violation is substantiated, the information may be transmitted to other government agencies.

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Reset Form

(For DWC use only)

COMPLAINT AGAINST

Physician's First Name _____ Physician's Last Name _____

Address where the Evaluation took place _____

City _____ Zip Code _____ Phone Number _____

Date of Evaluation _____ QME Panel Number _____

Panel Qualified Medical Evaluation ☐ Agreed Medical Evaluation ☐

COMPLAINANT

First Name _____ Last Name _____

Mailing Address _____

City _____ State _____ Zip Code _____

Daytime Phone Number _____ Fax Number _____ E-mail Address _____

If you are making a complaint and you are not the injured worker, please list the name of the injured worker.

Name of Injured Worker: _____

INFORMATON ABOUT THE CLAIM

If you are the injured worker, please list the name of the insurance company/employer and the name and telephone number of your claims adjuster.

Name of Claims Adjuster _____ Phone Number of Claims Adjuster _____

Insurance Company or Employer _____ Claim Number _____

If your complaint involves an examination performed by a Qualified Medical Examiner in a case pending before the Workers' Compensation Appeals Board, please list the case and the case number. If the WCAB has held a hearing or issued any orders about this examination, please attach the minutes of hearing or the Board order to this complaint.

Case Name _____

Case Number(s) _____

GIVE US THE DETAILS LOF YOUR COMPLAINT

Please list the details of your complaint and attach any documents that you believe would be useful for the investigation. Use as many additional sheets paper as necessary to tell us about your complaint.

Date: _____

_____
Signature