SAVE PRINT CLEAR

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(k).

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 Industrial Medical Council (IMC), 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) A copy of the **Summary Rating**;
(3) A copy of the **Qualified Medical Evaluation (QME) or Treating Physician (TP) report**;
(4) Other information supporting the request.

Employee Name:		**Disability Evaluation Unit File Number:**	
Employee Address:		**Employer/Insurer Claim Number:**	
Employer/Adjusting Agency:		**Employee's Social Security Number:**	
Employer/Adjusting Agency Address:		**Date of Injury:**	

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 procedures not followed by QME/TP ☐ Rating was incorrectly calculated

Explanation:

Reconsideration of Summary Rating is being requested by:_____.
(Injured worker/Employer/Claims Adjusting Agency)

PROOF OF SERVICE BY MAIL (Instructions on Reverse)

On _____ I served a copy of this Request for Reconsideration of Summary Rating on
(date)
_____ at _____ by placing
*(name of **employee** or **claims administrator**)* *(address)*
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_____

DEU Form 103 (Rev. 06/02)

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)**

On **#1** *(date)* I served a copy of this Request for Reconsideration of Summary Rating on **#2** *(name of **employee** or **claims administrator**)* at **#3** *(address)* 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.