STATE OF CALIFORNIA Arnold Schwarzenegger, Governor

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
MEDICAL UNIT
P. O. Box 71010
Oakland, CA 94612
Tel. No.: (510) 286-3700 or 1-(800) 794-6900

NOTICE OF QME COMPETENCY EXAMINATION October 25, 2008

The Division of Workers' Compensation (DWC) will administer the next Qualified Medical Evaluator (QME) Competency Examination on **Saturday, October 25, 2008.**

Physicians who wish to take the exam on October 25, 2008, must submit a completed original Application for Appointment as Qualified Medical Evaluator (QME Form 100, Rev.1/06) **and** Registration for QME Competency Examination (QME Form 102, Rev.1/06). The Application for Appointment as QME and all required documentation must be reviewed and approved by the DWC before a physician can be registered for the exam, (Title 8, California Code of Regulations §§10, 11). The application must be **postmarked by September 11, 2008**, in order to qualify for this exam. Qualified registrants will receive by mail a confirmation letter along with a Candidate Information Booklet. Please keep a copy for your records. The DWC is not responsible for late or lost applications.

All physicians are required to pay a non-refundable/non-rollover $125.00 fee to sit for any upcoming QME examination. (Title 8, California Code of Regulations § 11(f)(2)) Before appointment as QME, the physician shall complete a course in disability evaluation report writing, approved by the Administrative Director. (Labor Code § 139.2)

NOTE: Only physicians who were registered for the past QME exam on April 26, 2008, and who retake the exam in October 2008, may submit their registration without the Application form since their Application is already on file. The DWC may, however, request current status of expired documentation, i.e., expired license, etc.)

The DWC will assess your annual QME fee after you have successfully passed the QME Competency Exam in order to activate your QME status.

Please call (510) 286-3700 for further assistance. You may obtain additional application forms at www.dwc.ca.gov.

Division of Workers' Compensation Medical Unit
(Enclosures)

For Use on the QME Application Form

IMPORTANT: PLEASE USE THREE LETTER SPECIALTY CODE WHEN COMPLETING BLOCK 8 OF APPLICATION FORM

MD/DO SPECIALTY CODES

MAI Allergy and Immunology
MAA Anesthesiology
MRS Colon & Rectal Surgery
MDE Dermatology
MEM Emergency Medicine
MFP Family Practice - MD
OFP Family Practice - DO
OFM Family Practice - DO - Including Osteopathic Manipulation
MPM General Preventive Medicine
MOH Hand - Orthopaedic Surgery
MPH Hand - Plastic Surgery
MSH Hand - Surgery
MMM Internal Medicine
MMV Internal Medicine - Cardiovascular Disease
MME Internal Medicine - Endocrinology Diabetes and Metabolism
MMG Internal Medicine - Gastroenterology
MMH Internal Medicine - Hematology
MMI Internal Medicine - Infectious Disease
MMO Internal Medicine - Medical Oncology
MMN Internal Medicine - Nephrology
MMP Internal Medicine - Pulmonary Disease
MMR Internal Medicine - Rheumatology
MOQ Medicine - Otherwise Qualified
MPB Neurological Surgery-Including Back
MPN Neurology
MNS Neurological Surgery
MNM Nuclear Medicine
MOG Obstetrics and Gynecology
MPO Occupational Medicine
MOP Ophthalmology
MOS Orthopaedic Surgery
MOB Orthopaedic Surgery - Including Back
MTO Otolaryngology
MAP Pain Management - Anesthesiology
MPP Pain Management - Pain Medicine
MHA Pathology
MEP Pediatrics
MPR Physical Medicine & Rehabilitation
MPS Plastic Surgery
MPD Psychiatry
MRY Radiology
MSY Surgery
MSG Surgery - General Vascular
MTS Thoracic Surgery
MPT Toxicology - Occupational Medicine
MET Toxicology - Emergency Medicine
MUU Urology

NON-MD/DO SPECIALTY CODES

*denotes a doctor of chiropractic who has completed a chiropractic post-graduate specialty program

ACA Acupuncture
DCH Chiropractic
DCN Chiropractic - Neurology*
DCO Chiropractic - Orthopaedic*
DCR Chiropractic - Radiology*
DCS Chiropractic - Sports Medicine*
DCT Chiropractic - Rehabilitation*
DEN Dentistry
OPT Optometry
POD Podiatry
PSY Psychology
PSN Psychology - Clinical Neuropsychology

APPLICATION FOR APPOINTMENT AS QUALIFIED MEDICAL EVALUATOR

For the Department of Industrial Relations
Division of Workers' Compensation
P. O. Box 420603
San Francisco, CA 94142-0603

FOR DWC USE ONLY
QME NO.:
INPUT DATE:
INPUT BY:

BLOCK 1 (FOR ALL APPLICANTS) PLEASE TYPE OR PRINT LEGIBLY

Please list your primary location. DO NOT USE P. O. BOX. Additional locations may be added when your fee assessment is paid. You will be billed shortly after passing the QME test.

LAST NAME	FIRST NAME	MI	JR/SR

BUSINESS ADDRESS WHERE QME EVALUATIONS WILL TAKE PLACE	CITY	ZIP + 4

MAILING ADDRESS FOR CORRESPONDENCE, IF DIFFERENT	CITY	ZIP + 4

(AREA CODE) PHONE NO.	CAL. PROFESSIONAL LICENSE NUMBER	EXPIRATION (MM/YY)	YEAR ENTERED PRACTICE

PROCEED TO BLOCK 2

BLOCK 2 (FOR ALL APPLICANTS) IMPORTANT: BLOCK 2 Must be fully completed before proceeding.

PROFESSIONAL EDUCATION INDICATE DEGREE OBTAINED (e.g. MD, DC, DO, Ph.D, Psy.D, Ed.D, etc.)

COLLEGE ,UNIVERSITY or MEDICAL SCHOOL

CITY	STATE	DATE OF DEGREE	DEGREE

If MD or DO, COMPLETE BLOCKS 3,6,7,8,9,10
If DC, COMPLETE BLOCKS 4,7,8,9,10
If Ph.D, Psy.D or Ed.D, COMPLETE BLOCKS 5,7,8,9
Other Degrees, COMPLETE BLOCKS 7,8,9,10

BLOCK 3 (FOR MDs AND DOs ONLY) POSTGRADUATE TRAINING:

NOTE: For MDs or DOs who are not board certified, state law requires successful completion of a residency training program accredited by the American Council on Graduate Medical Education or the American Osteopathic Association. Fellowships will not be accepted in lieu of accredited residency training.

DO NOT ENTER "SEE RESUME"

	Hospital/Facility	Location (City/State)	Type	Year From	Year To
PGY 1 or INTERNSHIP:					
RESIDENCY :					
RESIDENCY :					
RESIDENCY:					
FELLOWSHIP:					

IMPORTANT: IF APPLICANT IS BOARD CERTIFIED, PLEASE PROVIDE COPY OF BOARD CERTIFICATE(S). OTHERWISE, PLEASE PROVIDE COPY OF CERTIFICATE(S) OF COMPLETION OF POSTGRADUATE TRAINING.

PROCEED TO BLOCK 6 SUBMIT DOCUMENTATION

BLOCK 4 (FOR DCs ONLY)
NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS

	Yes	No
1) I am certified in California workers compensation evaluation by either a California professional chiropractic association or an accredited California college recognized by the Administrative Director (i.e. IDE Certificate (min. 44 hrs. eff. 4/15/99)).	☐	☐
2) I have completed a chiropractic postgraduate specialty program of a minimum of 300 hours taught by a school or college recognized by the Administrative Director, the Board of Chiropractic Examiners and the Council on Chiropractic Education.	☐	☐

PROCEED TO BLOCK 7 SUBMIT DOCUMENTATION

BLOCK 5 (FOR Ph.Ds, Psy.Ds AND Ed.Ds ONLY)
NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS

	Yes	No
1) I am board certified in clinical psychology by the American Board of Professional Psychology, Inc.	☐	☐
2) I have a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology, from a university or professional school recognized by the Administrative Director and have not less than five years postdoctoral experience in the diagnosis and treatment of emotional and mental disorders.	☐	☐
3) I have not less than five years postdoctoral experience in the diagnosis and treatment of emotional and mental disorders and I have served as an Agreed Medical Evaluator (AME) on eight or more occasions prior to January 1, 1990. (Please provide documentation of 8 AMEs, i.e. AME cover letters, first page of the reports, or a sworn statement made under penalty of perjury).	☐	☐

PROCEED TO BLOCK 7 SUBMIT DOCUMENTATION

BLOCK 6 (FOR MDs AND DOs ONLY)
NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS

	Yes	No
1) I am board certified in the specialty for which I am applying to become a QME by a board recognized by the Administrative Director and the Medical Board of California or the Osteopathic Medical Board of California.	☐	☐
2) I completed postgraduate training in the specialty at an institution recognized by the ACGME or the American Osteopathic Association.	☐	☐
3) I have qualifications that the Administrative Director and the Medical Board of California or the Osteopathic Medical Board of California both deem to be equivalent to board certification in a specialty. (Please submit documentation from the Medical Board).	☐	☐

PROCEED TO BLOCK 7 SUBMIT DOCUMENTATION

BLOCK 7 (FOR ALL APPLICANTS)

NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS

	TRUE	FALSE
1) I devote at least one-third of my total practice time to providing direct medical treatment (Direct Medical Treatment is that special phase of the health care provider-patient relationship which (1) attempts to clinically diagnose and alter or modify the expression of a non-industrial illness, injury or pathological condition; or (2) attempts to cure or relieve the effects of an industrial injury.)	☐	☐
2) I have served as an Agreed Medical Evaluator (AME) on eight (8) or more occasions in the 12 months prior to submitting this application. (Submit documentation of 8 AMEs, i.e. AME cover letters, first page of reports or a sworn statement made under penalty of perjury.)	☐	☐

PROCEED TO BLOCK 8

BLOCK 8 (FOR ALL APPLICANTS)

PLEASE INDICATE SPECIALTY(IES) FOR WHICH YOU ARE APPLYING TO DO QME EXAMS (USE ENCLOSED SPECIALTY CODE LIST)

Professional practice specialty code: ☐ Professional practice specialty code: ☐ Professional practice specialty code: ☐

Reminder: For MDs & DOs, a copy of your Board Certification or documentation of completion of a training program accredited by the American College of Graduate Medical Education or the American Osteopathic Association must be submitted. For DCs, a certificate from postgraduate specialty diplomate program must be submitted for each specialty.

PROCEED TO BLOCK 9

BLOCK 9 (FOR ALL APPLICANTS, IF COMPLETED)

I have completed a disability evaluation report writing course approved by the Administrative Director.

Course: ______________________ Date of Course: ______________

PROCEED TO BLOCK 10

BLOCK 10 (FOR ALL APPLICANTS)

AFFIRMATIONS: Initialling each box affirms that you have read and agree to each of the statements.

	INITIAL EACH BOX
License Status	
A. My license to practice medicine is active and is neither restricted nor encumbered by suspension, interim suspension or probation. I certify that I have not been convicted of either a misdemeanor or felony related to my practice or a crime of moral turpitude.	☐
B. I agree to notify the Administrative Director if my license to practice medicine is placed on suspension, interim suspension, probation or is restricted by my licensing agency. I further agree to notify the Administrative Director if I am convicted of a misdemeanor or felony related to my practice or a crime of moral turpitude. (Do not initial if your statement is untrue, attach an explanation on a seperate piece of paper.) I understand that the Administrative Director may deny my application or conditionally accept my application if my license is on probation with my licensing authority.	☐
Financial Interest	
C. I agree that I shall abide by all Administrative Director regulations. I will not refer patients to facilities in which I or my family members have a financial interest , except as permitted by law. I agree I shall not offer, deliver, receive or accept any rebate, refund, commission, preference, patronage, dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred evaluation or consultation. I agree not to solicit to provide medical treatment to an injured employee for any injury for which I have done a QME evaluation. I have not performed a QME evaluation prior to appointment as a QME by the Administrative Director.	☐

Cont'd of BLOCK 10 (FOR ALL APPLICANTS)

Verification

I have used all reasonable diligence in preparing and completing this application. I have reviewed this completed application and to the best of my knowledge the information contained herein and in the attached supporting documentation is true, correct and complete. Failure to provide truthful information shall result in denial of applicants appointment and/or disciplinary action. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on ________ **(MM/DD/YY)** **at** ________ **County** **CA** ________ **Applicant's Signature**

IMPORTANT: Your application for appointment as a QME shall be returned if it is incomplete. Please check:

1) That your application is fully completed, dated and signed with an original signature. We will not accept faxed applications. Please also submit statement of citizenship form.

2) All necessary documentation is attached:

a) All applicants - A Copy of your current California Professional License.

b) MDs, DOs - A copy of your board certification or certificate(s) of completion of a residency training program accredited by the American College of Graduate Medical Education or the American Osteopathic Association. Please provide for all specialties in which you are requesting appointment to perform QME exams.

c) DCs - A copy of your certificate in California Workers' Compensation Evaluation or a copy of your certificate from postgraduate specialty diplomate program. For DC specialties other than DCH (e.g. DCR) a copy of your certificate of completion of 300 hours from postgraduate specialty diplomate program is required.

d) Ph.D, Psy.D and Ed.D- A copy of your professional diploma(s). Copy of board certification, if appropriate.

e) ALL OTHERS - A copy of your professional diploma(s).

f) A copy of completion certificate from the report writing course required by Title 8 CCR §11.5, if completed.

This document must be submitted prior to obtaining your appointment as a QME.

A PUBLIC DOCUMENT

PRIVACY NOTICE - The Information Practices Act of 1977 and the Federal Privacy Act require the Administrative Director to provide the following notice to individuals who are asked by a governmental entity to supply information for appointment as a Qualified Medical Evaluator (QME).

The principal purpose for requesting information from QMEs is to administer the QME program within the California workers' compensation system. Additional information may be requested if your application is denied and/or a disciplinary action is taken.

The California Labor Code requires every QME physician to meet certain statutory requirements. Physicians are required by the Labor Code to provide: name; business address/addresses; professional education; training; license number; year entered practice and other requirements deemed necessary by the Administrative Director. It is mandatory to furnish all the appropriate information requested by the Administrative Director. Failure to provide all of the requested information may result in the denial of the application.

As authorized by law, information furnished on this form may be given to: you, upon request; the public, pursuant to the Public Records Act; a governmental entity, when required by state or federal law; to any person, pursuant to a subpoena or court order or pursuant to any other exception in Civil Code § 1798.24.

An individual has a right of access to records containing his/her personal information that are maintained by the Administrative Director. An individual may also amend, correct, or dispute information in such personal records (Civil Code § 1798.34-1798.37).

Requests should be sent to:

Division of Workers' Compensation-Medical Unit
P.O. Box 420603
San Francisco, CA 94142-0603
Tel: (510) 286-3700 or 1(800) 794-6900
Fax: (510) 622-3467; E-mail: www.dir.ca.gov

You may request a copy of the Division of Workers' Compensation policy and procedures for inspection of records at the above address. Copies of the procedures and all records are ten cents ($0.10) per page, payable in advance. (Civil Code § 1798.33).

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
MEDICAL UNIT
1515 Clay Street, 17th Floor
Oakland, CA 94612
Tel. No.: (510) 286-3700 or 1-(800) 794-6900

ADDRESS REPLY TO:
P. O. Box 71010
Oakland, CA 94612

REGISTRATION FOR QME COMPETENCY EXAMINATION October 25, 2008

PLEASE COMPLETE THIS REGISTRATION FORM AND RETURN POSTMARKED NO LATER THAN ***SEPTEMBER 11, 2008*** . THE DIVISION OF WORKERS' COMPENSATION (DWC) IS NOT RESPONSIBLE FOR LATE OR LOST APPLICATIONS. PLEASE SEND YOUR REGISTRATION AND APPLICATION FORMS TO:

DIVISION OF WORKERS' COMPENSATION - ATTN: QME EXAM - MEDICAL UNIT

MAILING ADDRESS:
P. O. BOX 71010
OAKLAND, CA 94612

STREET ADDRESS FOR EXPRESS DELIVERY:
1515 CLAY STREET 17TH FLR.
OAKLAND, CA 94612

NAME: ______________________, ______________________, ________, ________
LAST FIRST MI JR./SR.

ADDRESS: (street address) ______________________________________

(city) ______________________, CA (zip) ______________ (+4) __________

PHONE NUMBER: ( ) - FAX NUMBER: ( ) -

PHYSICIAN'S LICENSE NUMBER: ________ - ______________
Prefix Number

EXAM DATE & TIME: October 25, 2008

Registration begins at 9:30 a.m.
Examination begins at 10:00 a.m.

PREFERRED EXAM LOCATION: (TEST SITE WILL BE INDICATED ON YOUR CONFIRMATION LETTER FROM CPS.)

❒ *Northern California* ❒ *Southern California*

DO YOU HAVE ANY NEED FOR ACCOMODATIONS DUE TO A DISABILITY OR RELIGIOUS CONFLICT?

❒ *No* ❒ *Yes* (*Please see the Special Administration Procedures at the back of this page.)*

AFFIRMATIONS and VERIFICATION

I have used all reasonable diligence in preparing and completing this application. I have reviewed this completed application and to the best of my knowledge the information contained herein and in the attached supporting documentation is true, correct and complete. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that I must keep my license to practice active and that it currently is active. I certify that I am not currently on probation with my licensing board nor on any court-ordered probation. I certify I will notify the DWC of any of the following events: a) change in my license status; b) any past or future conviction related to the conduct of my practice or for any crime of morel turpitude; and c) upon being placed on probation by my licensing board or by any court-ordered probation.

I certify that all the information and supporting documentation which I have previously submitted to the DWC with earlier QME application(s) is bona fide, true and correct.

Executed on: ______________ at ______________ ______________
mm/dd/yy County & State Applicant's Signature

(over)

REGISTERING FOR SPECIAL ADMINISTRATION PROCEDURES

Examinee with a Disabling Condition or Religious Conflict

Special administration arrangements can be provided for examinees who, due to a disability or religious conflict, would not be able to take the test under standard conditions. Requests for special arrangements must be made by the REGULAR REGISTRATION DEADLINE. It may not be possible to honor requests for special testing arrangements received after the regular registration deadline.

Individuals whose religious convictions prohibit them from taking tests on Saturdays or religious holidays may request a special test administration

All of the following must be submitted if special arrangements are needed due to a disability:

- a letter from you describing the condition and the specific special arrangements requested; and
- a completed registration form.

YOUR PROFESSIONAL LICENSE NUMBER AND TELEPHONE NUMBER MUST APPEAR ON ALL CORRESPONDENCE.

If you need special facilities (e.g., wheelchair accessible building or restrooms), please notify by letter, Cooperative Personnel Services (CPS) at 241 Lathrop Way, Sacramento, CA 95815. In this case, it is not necessary to submit any medical documentation.

Special arrangements for the following conditions can be accommodated at ALL test sites:

- special seating (e.g., due to pregnancy)
- wheelchair accessible facilities
- use of magnifying devices or large-print tests (e.g., for those with visual impairments).

Arrangements that require SUBSTANTIAL CHANGES IN TESTING CONDITIONS may be accommodated only at selected test sites. If it is necessary to relocate you to accommodate any other type of request, you will be contacted directly to discuss the arrangement.

STATE OF CALIFORNIA Arnold Schwarzenegger, Governor

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
MEDICAL UNIT
P. O. Box 71010
Oakland, CA 94612
Tel. No.: (510) 286-3700 or 1-(800) 794-6900

ALL PHYSICIANS REQUIRED TO PAY NON-REFUNDABLE/NON-ROLLOVER $125.00 FEE

Effective with the September 20, 2003 QME exam, all physicians are required to pay a non-refundable/non-rollover $125.00 fee to sit for any upcoming Qualified Medical Evaluator examination. (Title 8, California Code of Regulations §11(f)(2)).

If you have any questions regarding the fee, please call Joanne Van Raam at 1-800-794-6900 ext. 2004 or 510-628-2004 for further information.

Please send this completed form with a $125.00 check payable to "**Division of Workers' Compensation**" along with your application for appointment as QME, QME competency exam registration form and documentation to:

Division of Workers' Compensation
Medical Unit
P O Box 71010
Oakland, CA 94612
Attn: Joanne Van Raam, Examination Coordinator

NAME:____________________ CA PHYSICIAN'S NUMBER:________________

ADDRESS: ____

CITY: ____________________ STATE: ________ ZIP: ____________

FAX NUMBER:____________________ E-MAIL ADDRESS:____________________

THANK YOU,
DIVISION OF WORKERS' COMPENSATION

STATE OF CALIFORNIA Arnold Schwarzenegger, Governor

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
MEDICAL UNIT
P. O. Box 71010
Oakland, CA 94612
Tel. No.: (510) 286-3700 or 1-(800) 794-6900

12 HOUR REPORT WRITING COURSE PROVIDERS

Effective January 1, 2001, "A physician seeking appointment as a Qualified Medical Evaluator on or after January 1, 2001, shall also complete prior to appointment, a 12 hour course on Disability Evaluation Report Writing approved by the DWC", (LC §139.2).

The following are the providers approved by the Division of Workers' Compensation:

NAME	LOCATION	PHONE NUMBER
James Platto, DC/Dennis Sosine, DC	Southern California	209-966-5652
Dennis Sosine, DC/James Platto, DC	Northern California	925-676-9245
Dana Livingstone-Lopez	Southern/Northern CA	760-944-6769
California Chiropractic Association (CAA)/California Society of Industrial Medicine & Surgery (CSIMS)	Southern/Northern CA	916-648-2727
Fred Lerner, DC, Lerner Education	Southern California	800-838-8584
California Orthopedic Association (COA)	Southern California	916-454-9884

These are the only report writing course providers approved at this time. You must attend a report writing course prior to being appointed as a QME, but are **not** required to take the course prior to the QME examination, unless you wish to.

If you have any further questions you may call Joanne Van Raam, Exam Coordinator at 1-800-794-6900 ext 2004. Thank you for your interest in the Qualified Medical Evaluator program.

Sincerely,
Division of Workers' Compensation

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
MEDICAL UNIT
P. O. Box 71010
Oakland, CA 94612
Tel. No.: (510) 286-3700 or 1-(800) 794-6900

SUGGESTED REFERENCES

(For Physicians planning to take the QME Examination)

Physician's Guide to Medical Practice in the California Workers' Compensation System, An IMC publication, Winter 2001, 3rd edition. (Available from the DWC/Manual Order, PO Box 71010, Oakland, CA 94612; $15.00) Also, available through the Internet at www.dir.ca.gov/dwc/medicalunit/toc.pdf. or www.dwc.ca.gov, click "Publications", click "The Physician's Guide to Medical Practice in the California Workers' Compensation System".

Provisions of the California Code of Regulations; Title 8, Industrial Relations, are part of the study material for the QME examination. Information is available through the DWC's website, www.dwc.ca.gov, click "Laws and Regulations". (A copy is included with the purchase of The Physician's Guide to Medical Practice).

Herlick, SD. The California Workers' Compensation Handbook (26th Edition). Available Dec. 2007 from Matthew Bender & Co., Inc.
(To order: 1-800-223-1940 approximately $112.00, product #80283-16).

Workers' Compensation Laws of California. 2008 Edition. Matthew Bender & Co., Inc. (To place an order: 1-800-223-1940; approximately $63.00, product # 840). Especially sections: 139.2, 139.3, 139.31, 4060, 4061, 4062, 4600, 4628. Information is available through the DWC's website, www.dwc.ca.gov, click "Laws and Regulations".

Thurber, P. Evaluation of Industrial Disability, 2nd ed. Oxford University Press, 1960 (Available from UCSF Bookstore, 500 Parnassus Ave., San Francisco, CA 94143. To place an order: 1-800-846-2144; $24.95).

SB 899 (2004), SB 228 (2003), AB 749 (2002). The senate and assembly bills are located at www.leginfo.ca.gov

AMA Guides to the Evaluation of Permanent Impairment 1-800-621-8335 or www.ama-assn.org

THE PHYSICIAN'S GUIDE TO MEDICAL PRACTICE IN THE CALIFORNIA WORKERS' COMPENSATION SYSTEM

(3RD Edition, printed 12/01)

The Manual covers:

- An overview of the California Workers' Compensation System
- The basic concepts of:
  - Compensability
  - Disability
  - The role of treating/evaluating physician's in the work compensation system
  - The evaluator's conduct & ethics
  - Guidelines for the evaluator's office staff
  - Various forms and resource materials

Order your copy today!

(please type or print legibly)

Return with a check for $15.00, payable to: **Division of Workers' Compensation**

Mail to: Division of Workers' Compensation – Attn: Medical Unit
P O Box 71010, Oakland, CA 94612

NAME: ______________________________

COMPANY NAME: ______________________________

STREET ADDRESS: ______________________________
(No P. O. Box Address Please)

CITY: ______________ STATE: __________ ZIP: ____________

PHONE NUMBER: ______________________________