State of California
Division of Workers' Compensation-Medical Unit
QME Appointment Notification Form

Please complete this form in its entirety. *The Administrative Director requires that you serve this appointment notification form on the employee and the claims administrator, or, if none the employer, and their attorneys in a represented case, if known, within five (5) business days after having scheduled the injured worker to be seen for a QME comprehensive medical-legal evaluation. You may not cancel the appointment less than six (6) calendar days prior to the appointment date, except for good cause (See, 8 Cal. Code Regs. §34). If you reschedule an appointment, review regulation 34 and the ethical rules in regulation 41 (See, 8 Cal Code Regs. §§ 34, 41(a) (7) and (a) (8)).*

Employee Information *(Completion of this section is required)*

Employee Name _____ Phone Number _____

Employee Street Address _____ Employee City _____ State _____ Zip Code _____

Date of Injury _____ Panel Number _____ Claim or Case Number _____

Employer Information

Employer Name _____

Employer Street Address _____ Employer City _____ State _____ Zip Code _____

Claims Administrator Information *(Completion of this section is required)*

Claims Administrator Name (Insert the name of the person handling the claim) _____ Phone Number _____

Claims Administrator Company (Insert the name of the company handling the claim) _____

Claims Administrator Street Address _____ Claims Administrator City _____ State _____ Zip Code _____

Appointment Information *(Completion of this section is required)*

Date of appointment call: _____ Date of Appointment: _____ Time of appointment: _____

Examination address _____ Examination City: _____ Zip Code _____

Records should be sent to the following address: 13160 Mindanao Way, Suite 310 (Street address or P.O. Box) Marina del Rey, CA (City:) 90292 (Zip Code)

Is a certified interpreter required? _____ If an interpreter is required, indicate language: _____

QME Name: _____

QME Street Address _____ QME City _____ State CA Zip Code _____

Date Signed: _____ Signature of the QME: _____

Note to Claims Administrator: The Administrative Director's regulation 10160 requires you to forward a completed, DWC-AD form 101(DEU) (Request for Summary Rating Determination of Qualified Medical Evaluator's Report) (see, 8 Cal. Code Regs. §§ 10160 and 10161) together with all medical reports and medical records prior to the scheduled examination with the QME. You must also provide the employee with a DWC-AD form 100 (DEU) (Employee's Disability Questionnaire)(See, 8 Cal. Code Regs. §§ 10160 and 10161) prior to the examination.

Declaration of Service

I declare that I am a resident of or employed in the county where the mailing took place. I am over the age of eighteen years and I am not a party to this case, my business or residence address is:

13160 Mindanao Way, Suite 310, Marina del Rey, CA 90292

On_____, I served this QME Appointment Notification Form, the original, or a true and correct copy of the original, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

A	depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.
B	placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.
C	placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.
D	placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*
E	personally delivering the sealed envelope to the person or firm named below at the address shown below.

B — Method of Service | Person or firm served | Street Address

City | State | Zip Code

B — Method of Service | Person or firm served | Street Address

City | State | Zip Code

B — Method of Service | Person or firm served | Street Address

City | State | Zip Code

B — Method of Service | Person or firm served | Street Address

City | State | Zip Code:

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:_____ at Marina del Rey , California.

Type or print name Simon Lee

Signature Simon Lee

ORTHOLEGAL PRACTICE RULES & POLICIES

By requesting service as a Qualified Medical Evaluator in an initial evaluation, re-evaluation, supplemental report, or deposition, both parties agree to comply with the following:

EVALUATIONS/RE-EVALUATIONS

- OrthoLegal must be provided current demographic information and the Panel upon requesting an appointment. One or both parties must notify OrthoLegal of changes to the demographic information as they occur or upon future correspondence.
- Insurance carrier or their counsel must provide billing policies and procedures prior to the completion of the evaluation unless otherwise notified by OrthoLegal staff.
- OrthoLegal reserves its right to administratively re-schedule evaluations at its discretion. OrthoLegal will notify both parties via written and electronic communication if such a re-scheduling occurs.
- No additional individuals are allowed to attend the evaluation suite and examination room beyond the injured worker and the interpreter. No children or other dependents will be allowed into the evaluation suite, even if childcare arrangements could not be made. Family members or other associates may be allowed if they medically assist or are otherwise required to assist the completion of the evaluation but there is no guarantee that they will be permitted to be present during the examination and may not provide interpretation services
- **Duration of an evaluation is up to 4-6 hours from the scheduled start time. Bringing w ater and a snack are recommended; if applicants leave the evaluation site their evaluation will be considered a failed appointment.**
- **Applicants should be advised to continue their usual medications on the date of evaluation to avoid a medical emergency requiring care.**

PAYMENTS

- All payments of fees must be paid by check. No other means of payment, including Virtual Credit Card (VCC), POS Card, etc. will be accepted.

INTERPRETING

- If the injured worker is not fluent in the English language, the employer's attorney or insurance carrier and their counsel **must furnish** a certified interpreter in the injured worker's fluent language.
- One or both parties must provide the name and contact information of the interpreter when that information becomes available and ahead of the appointment.
- The interpreter must not interfere with the doctor's ability to conduct the evaluation, disrespect, or abuse the doctor and his/her staff. The evaluation may be marked failed for interference or unprofessional conduct of the interpreter.
- If either party fails to provide an interpreter, the administrative staff will attempt to utilize an available certified interpreter present provided to another injured worker without notice. If one is available, the parties consent to using that available interpreter and to be billed by their vendor.

CANCELLATIONS

- The elected Qualified Medical Evaluator and his/her administrative staff may administratively cancel and re-schedule an evaluation should the need arise. The parties will not be billed a no-show fee for an administrative cancellation or re-scheduling.
- If one party objects to the setting of the appointment more than **6 business days** from the date of the evaluation, the parties will not be billed a no-show/cancellation fee.
- The parties will be billed a cancellation/no-show fee in the event of:
  - Failure of the injured worker to appear at the scheduled date/time and location for his/her evaluation.
    - We request that the injured worker and interpreter check in 1 hour before the evaluation start time for check-in and paperwork.
    - The injured worker will be marked a "no-show" by the medical staff if they fail to appear after **30 minutes** past the scheduled start time.
    - If the injured work fails to notify the medical staff of tardiness on the date of the evaluation, late arrivals are not guaranteed to be accommodated and would be the same as a failure to appear.
    - For the safety of other applicants and our staff, applicants will be rescheduled and considered an untimely cancellation if they have upper respiratory symptoms or other symptoms of communicable disease.
    - If a booked interpreter appears at the evaluation but leaves before the evaluation has completed, the evaluation will be deemed a failed appointment subject to a cancellation/no- show fee.
    - One or both parties request that the evaluation be cancelled within **6 business days** of the date of the scheduled evaluation.
    - One party objects to the evaluation or scheduling the evaluation within **6 business days** before the date of the evaluation. (LC §9795)
  - The cancellation fee of **$503.75** per Labor Code §9795 will be billed to the parties and is expected to be paid should the parties agree to continue using the selected Panel Qualified Medical Evaluator.

DEPOSITIONS

- If the parties wish to depose the Qualified Medical Evaluator, the doctor's deposition fees are **$910.00** and must be received by OrthoLegal no less than 2 weeks before the date of the deposition. If no payment is received by that date, the deposition will be administratively cancelled.
- All payment instructions for deposition fees will be provided by OrthoLegal at the time of scheduling, including untimely cancellations which will incur the maximum allowable fee.

These rules and practices are subject to change. OrthoLegal will attempt resolution of an issue with the above rules to an amicable and reasonable standard on a case-by-case basis, but this is not guaranteed.

OrthoLegal has complied with all rules, regulations, and timely served its reporting, OrthoLegal reserves its right to seek all remedy to recover its lost costs and fees, including but not limited to, seeking WCAB intervention as a medical- legal cost petitioner.

State of California
Division of Workers' Compensation-Medical Unit
QME Appointment Notification Form

Please complete this form in its entirety. *The Administrative Director requires that you serve this appointment notification form on the employee and the claims administrator, or, if none the employer, and their attorneys in a represented case, if known, within five (5) business days after having scheduled the injured worker to be seen for a QME comprehensive medical-legal evaluation. You may not cancel the appointment less than six (6) calendar days prior to the appointment date, except for good cause (See, 8 Cal. Code Regs. §34). If you reschedule an appointment, review regulation 34 and the ethical rules in regulation 41 (See, 8 Cal Code Regs. §§ 34, 41(a) (7) and (a) (8)).*

Employee Information *(Completion of this section is required)*

Employee Name _____ Phone Number _____

Employee Street Address _____ Employee City _____ State _____ Zip Code _____

Date of Injury _____ Panel Number _____ Claim or Case Number _____

Employer Information

Employer Name _____

Employer Street Address _____ Employer City _____ State _____ Zip Code _____

Claims Administrator Information *(Completion of this section is required)*

Claims Administrator Name (Insert the name of the person handling the claim) _____ Phone Number _____

Claims Administrator Company (Insert the name of the company handling the claim) _____

Claims Administrator Street Address _____ Claims Administrator City _____ State _____ Zip Code _____

Appointment Information *(Completion of this section is required)*

Date of appointment call: _____ Date of Appointment: _____ Time of appointment: _____

Examination address _____ Examination City: _____ Zip Code _____

Records should be sent to the following address: 13160 Mindanao Way, Suite 310 (Street address or P.O. Box) Marina del Rey, CA (City:) 90292 (Zip Code)

Is a certified interpreter required? _____ If an interpreter is required, indicate language: _____

QME Name: _____

QME Street Address _____ QME City _____ State CA Zip Code _____

Date Signed: _____ Signature of the QME: _____

Note to Claims Administrator: The Administrative Director's regulation 10160 requires you to forward a completed, DWC-AD form 101(DEU) (Request for Summary Rating Determination of Qualified Medical Evaluator's Report) (see, 8 Cal. Code Regs. §§ 10160 and 10161) together with all medical reports and medical records prior to the scheduled examination with the QME. You must also provide the employee with a DWC-AD form 100 (DEU) (Employee's Disability Questionnaire)(See, 8 Cal. Code Regs. §§ 10160 and 10161) prior to the examination.

Declaration of Service

I declare that I am a resident of or employed in the county where the mailing took place. I am over the age of eighteen years and I am not a party to this case, my business or residence address is:

13160 Mindanao Way, Suite 310, Marina del Rey, CA 90292

On_____, I served this QME Appointment Notification Form, the original, or a true and correct copy of the original, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

A	depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.
B	placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.
C	placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.
D	placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*
E	personally delivering the sealed envelope to the person or firm named below at the address shown below.

B — Method of Service | Person or firm served | Street Address

City | State | Zip Code

B — Method of Service | Person or firm served | Street Address

City | State | Zip Code

B — Method of Service | Person or firm served | Street Address

City | State | Zip Code

B — Method of Service | Person or firm served | Street Address

City | State | Zip Code:

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:_____ at Marina del Rey , California.

Type or print name Simon Lee

Signature Simon Lee

ORTHOLEGAL PRACTICE RULES & POLICIES

By requesting service as a Qualified Medical Evaluator in an initial evaluation, re-evaluation, supplemental report, or deposition, both parties agree to comply with the following:

EVALUATIONS/RE-EVALUATIONS

- OrthoLegal must be provided current demographic information and the Panel upon requesting an appointment. One or both parties must notify OrthoLegal of changes to the demographic information as they occur or upon future correspondence.
- Insurance carrier or their counsel must provide billing policies and procedures prior to the completion of the evaluation unless otherwise notified by OrthoLegal staff.
- OrthoLegal reserves its right to administratively re-schedule evaluations at its discretion. OrthoLegal will notify both parties via written and electronic communication if such a re-scheduling occurs.
- No additional individuals are allowed to attend the evaluation suite and examination room beyond the injured worker and the interpreter. No children or other dependents will be allowed into the evaluation suite, even if childcare arrangements could not be made. Family members or other associates may be allowed if they medically assist or are otherwise required to assist the completion of the evaluation but there is no guarantee that they will be permitted to be present during the examination and may not provide interpretation services
- **Duration of an evaluation is up to 4-6 hours from the scheduled start time. Bringing w ater and a snack are recommended; if applicants leave the evaluation site their evaluation will be considered a failed appointment.**
- **Applicants should be advised to continue their usual medications on the date of evaluation to avoid a medical emergency requiring care.**

PAYMENTS

- All payments of fees must be paid by check. No other means of payment, including Virtual Credit Card (VCC), POS Card, etc. will be accepted.

INTERPRETING

- If the injured worker is not fluent in the English language, the employer's attorney or insurance carrier and their counsel **must furnish** a certified interpreter in the injured worker's fluent language.
- One or both parties must provide the name and contact information of the interpreter when that information becomes available and ahead of the appointment.
- The interpreter must not interfere with the doctor's ability to conduct the evaluation, disrespect, or abuse the doctor and his/her staff. The evaluation may be marked failed for interference or unprofessional conduct of the interpreter.
- If either party fails to provide an interpreter, the administrative staff will attempt to utilize an available certified interpreter present provided to another injured worker without notice. If one is available, the parties consent to using that available interpreter and to be billed by their vendor.

CANCELLATIONS

- The elected Qualified Medical Evaluator and his/her administrative staff may administratively cancel and re-schedule an evaluation should the need arise. The parties will not be billed a no-show fee for an administrative cancellation or re-scheduling.
- If one party objects to the setting of the appointment more than **6 business days** from the date of the evaluation, the parties will not be billed a no-show/cancellation fee.
- The parties will be billed a cancellation/no-show fee in the event of:
  - Failure of the injured worker to appear at the scheduled date/time and location for his/her evaluation.
    - We request that the injured worker and interpreter check in 1 hour before the evaluation start time for check-in and paperwork.
    - The injured worker will be marked a "no-show" by the medical staff if they fail to appear after **30 minutes** past the scheduled start time.
    - If the injured work fails to notify the medical staff of tardiness on the date of the evaluation, late arrivals are not guaranteed to be accommodated and would be the same as a failure to appear.
    - For the safety of other applicants and our staff, applicants will be rescheduled and considered an untimely cancellation if they have upper respiratory symptoms or other symptoms of communicable disease.
    - If a booked interpreter appears at the evaluation but leaves before the evaluation has completed, the evaluation will be deemed a failed appointment subject to a cancellation/no- show fee.
    - One or both parties request that the evaluation be cancelled within **6 business days** of the date of the scheduled evaluation.
    - One party objects to the evaluation or scheduling the evaluation within **6 business days** before the date of the evaluation. (LC §9795)
  - The cancellation fee of **$503.75** per Labor Code §9795 will be billed to the parties and is expected to be paid should the parties agree to continue using the selected Panel Qualified Medical Evaluator.

DEPOSITIONS

- If the parties wish to depose the Qualified Medical Evaluator, the doctor's deposition fees are **$910.00** and must be received by OrthoLegal no less than 2 weeks before the date of the deposition. If no payment is received by that date, the deposition will be administratively cancelled.
- All payment instructions for deposition fees will be provided by OrthoLegal at the time of scheduling, including untimely cancellations which will incur the maximum allowable fee.

These rules and practices are subject to change. OrthoLegal will attempt resolution of an issue with the above rules to an amicable and reasonable standard on a case-by-case basis, but this is not guaranteed.

OrthoLegal has complied with all rules, regulations, and timely served its reporting, OrthoLegal reserves its right to seek all remedy to recover its lost costs and fees, including but not limited to, seeking WCAB intervention as a medical- legal cost petitioner.

State of California
Division of Workers' Compensation-Medical Unit
QME Appointment Notification Form

Please complete this form in its entirety. *The Administrative Director requires that you serve this appointment notification form on the employee and the claims administrator, or, if none the employer, and their attorneys in a represented case, if known, within five (5) business days after having scheduled the injured worker to be seen for a QME comprehensive medical-legal evaluation. You may not cancel the appointment less than six (6) calendar days prior to the appointment date, except for good cause (See, 8 Cal. Code Regs. §34). If you reschedule an appointment, review regulation 34 and the ethical rules in regulation 41 (See, 8 Cal Code Regs. §§ 34, 41(a) (7) and (a) (8)).*

Employee Information *(Completion of this section is required)*

Employee Name _____ Phone Number _____

Employee Street Address _____ Employee City _____ State _____ Zip Code _____

Date of Injury _____ Panel Number _____ Claim or Case Number _____

Employer Information

Employer Name _____

Employer Street Address _____ Employer City _____ State _____ Zip Code _____

Claims Administrator Information *(Completion of this section is required)*

Claims Administrator Name (Insert the name of the person handling the claim) _____ Phone Number _____

Claims Administrator Company (Insert the name of the company handling the claim) _____

Claims Administrator Street Address _____ Claims Administrator City _____ State _____ Zip Code _____

Appointment Information *(Completion of this section is required)*

Date of appointment call: _____ Date of Appointment: _____ Time of appointment: _____

Examination address _____ Examination City: _____ Zip Code _____

Records should be sent to the following address: 13160 Mindanao Way, Suite 310 (Street address or P.O. Box) Marina del Rey, CA (City:) 90292 (Zip Code)

Is a certified interpreter required? _____ If an interpreter is required, indicate language: _____

QME Name: _____

QME Street Address _____ QME City _____ State CA Zip Code _____

Date Signed: _____ Signature of the QME: _____

Note to Claims Administrator: The Administrative Director's regulation 10160 requires you to forward a completed, DWC-AD form 101(DEU) (Request for Summary Rating Determination of Qualified Medical Evaluator's Report) (see, 8 Cal. Code Regs. §§ 10160 and 10161) together with all medical reports and medical records prior to the scheduled examination with the QME. You must also provide the employee with a DWC-AD form 100 (DEU) (Employee's Disability Questionnaire)(See, 8 Cal. Code Regs. §§ 10160 and 10161) prior to the examination.

Declaration of Service

I declare that I am a resident of or employed in the county where the mailing took place. I am over the age of eighteen years and I am not a party to this case, my business or residence address is:

13160 Mindanao Way, Suite 310, Marina del Rey, CA 90292

On_____, I served this QME Appointment Notification Form, the original, or a true and correct copy of the original, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

A	depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.
B	placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.
C	placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.
D	placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*
E	personally delivering the sealed envelope to the person or firm named below at the address shown below.

B — Method of Service | Person or firm served | Street Address

City | State | Zip Code

B — Method of Service | Person or firm served | Street Address

City | State | Zip Code

B — Method of Service | Person or firm served | Street Address

City | State | Zip Code

B — Method of Service | Person or firm served | Street Address

City | State | Zip Code:

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:_____ at Marina del Rey , California.

Type or print name Simon Lee

Signature Simon Lee

ORTHOLEGAL PRACTICE RULES & POLICIES

By requesting service as a Qualified Medical Evaluator in an initial evaluation, re-evaluation, supplemental report, or deposition, both parties agree to comply with the following:

EVALUATIONS/RE-EVALUATIONS

- OrthoLegal must be provided current demographic information and the Panel upon requesting an appointment. One or both parties must notify OrthoLegal of changes to the demographic information as they occur or upon future correspondence.
- Insurance carrier or their counsel must provide billing policies and procedures prior to the completion of the evaluation unless otherwise notified by OrthoLegal staff.
- OrthoLegal reserves its right to administratively re-schedule evaluations at its discretion. OrthoLegal will notify both parties via written and electronic communication if such a re-scheduling occurs.
- No additional individuals are allowed to attend the evaluation suite and examination room beyond the injured worker and the interpreter. No children or other dependents will be allowed into the evaluation suite, even if childcare arrangements could not be made. Family members or other associates may be allowed if they medically assist or are otherwise required to assist the completion of the evaluation but there is no guarantee that they will be permitted to be present during the examination and may not provide interpretation services
- **Duration of an evaluation is up to 4-6 hours from the scheduled start time. Bringing w ater and a snack are recommended; if applicants leave the evaluation site their evaluation will be considered a failed appointment.**
- **Applicants should be advised to continue their usual medications on the date of evaluation to avoid a medical emergency requiring care.**

PAYMENTS

- All payments of fees must be paid by check. No other means of payment, including Virtual Credit Card (VCC), POS Card, etc. will be accepted.

INTERPRETING

- If the injured worker is not fluent in the English language, the employer's attorney or insurance carrier and their counsel **must furnish** a certified interpreter in the injured worker's fluent language.
- One or both parties must provide the name and contact information of the interpreter when that information becomes available and ahead of the appointment.
- The interpreter must not interfere with the doctor's ability to conduct the evaluation, disrespect, or abuse the doctor and his/her staff. The evaluation may be marked failed for interference or unprofessional conduct of the interpreter.
- If either party fails to provide an interpreter, the administrative staff will attempt to utilize an available certified interpreter present provided to another injured worker without notice. If one is available, the parties consent to using that available interpreter and to be billed by their vendor.

CANCELLATIONS

- The elected Qualified Medical Evaluator and his/her administrative staff may administratively cancel and re-schedule an evaluation should the need arise. The parties will not be billed a no-show fee for an administrative cancellation or re-scheduling.
- If one party objects to the setting of the appointment more than **6 business days** from the date of the evaluation, the parties will not be billed a no-show/cancellation fee.
- The parties will be billed a cancellation/no-show fee in the event of:
  - Failure of the injured worker to appear at the scheduled date/time and location for his/her evaluation.
    - We request that the injured worker and interpreter check in 1 hour before the evaluation start time for check-in and paperwork.
    - The injured worker will be marked a "no-show" by the medical staff if they fail to appear after **30 minutes** past the scheduled start time.
    - If the injured work fails to notify the medical staff of tardiness on the date of the evaluation, late arrivals are not guaranteed to be accommodated and would be the same as a failure to appear.
    - For the safety of other applicants and our staff, applicants will be rescheduled and considered an untimely cancellation if they have upper respiratory symptoms or other symptoms of communicable disease.
    - If a booked interpreter appears at the evaluation but leaves before the evaluation has completed, the evaluation will be deemed a failed appointment subject to a cancellation/no- show fee.
    - One or both parties request that the evaluation be cancelled within **6 business days** of the date of the scheduled evaluation.
    - One party objects to the evaluation or scheduling the evaluation within **6 business days** before the date of the evaluation. (LC §9795)
  - The cancellation fee of **$503.75** per Labor Code §9795 will be billed to the parties and is expected to be paid should the parties agree to continue using the selected Panel Qualified Medical Evaluator.

DEPOSITIONS

- If the parties wish to depose the Qualified Medical Evaluator, the doctor's deposition fees are **$910.00** and must be received by OrthoLegal no less than 2 weeks before the date of the deposition. If no payment is received by that date, the deposition will be administratively cancelled.
- All payment instructions for deposition fees will be provided by OrthoLegal at the time of scheduling, including untimely cancellations which will incur the maximum allowable fee.

These rules and practices are subject to change. OrthoLegal will attempt resolution of an issue with the above rules to an amicable and reasonable standard on a case-by-case basis, but this is not guaranteed.

OrthoLegal has complied with all rules, regulations, and timely served its reporting, OrthoLegal reserves its right to seek all remedy to recover its lost costs and fees, including but not limited to, seeking WCAB intervention as a medical- legal cost petitioner.

State of California
Division of Workers' Compensation-Medical Unit
QME Appointment Notification Form

Please complete this form in its entirety. *The Administrative Director requires that you serve this appointment notification form on the employee and the claims administrator, or, if none the employer, and their attorneys in a represented case, if known, within five (5) business days after having scheduled the injured worker to be seen for a QME comprehensive medical-legal evaluation. You may not cancel the appointment less than six (6) calendar days prior to the appointment date, except for good cause (See, 8 Cal. Code Regs. §34). If you reschedule an appointment, review regulation 34 and the ethical rules in regulation 41 (See, 8 Cal Code Regs. §§ 34, 41(a) (7) and (a) (8)).*

Employee Information *(Completion of this section is required)*

Employee Name _____ Phone Number _____

Employee Street Address _____ Employee City _____ State _____ Zip Code _____

Date of Injury _____ Panel Number _____ Claim or Case Number _____

Employer Information

Employer Name _____

Employer Street Address _____ Employer City _____ State _____ Zip Code _____

Claims Administrator Information *(Completion of this section is required)*

Claims Administrator Name (Insert the name of the person handling the claim) _____ Phone Number _____

Claims Administrator Company (Insert the name of the company handling the claim) _____

Claims Administrator Street Address _____ Claims Administrator City _____ State _____ Zip Code _____

Appointment Information *(Completion of this section is required)*

Date of appointment call: _____ Date of Appointment: _____ Time of appointment: _____

Examination address _____ Examination City: _____ Zip Code _____

Records should be sent to the following address: 13160 Mindanao Way, Suite 310 (Street address or P.O. Box) Marina del Rey, CA (City:) 90292 (Zip Code)

Is a certified interpreter required? _____ If an interpreter is required, indicate language: _____

QME Name: _____

QME Street Address _____ QME City _____ State CA Zip Code _____

Date Signed: _____ Signature of the QME: _____

Note to Claims Administrator: The Administrative Director's regulation 10160 requires you to forward a completed, DWC-AD form 101(DEU) (Request for Summary Rating Determination of Qualified Medical Evaluator's Report) (see, 8 Cal. Code Regs. §§ 10160 and 10161) together with all medical reports and medical records prior to the scheduled examination with the QME. You must also provide the employee with a DWC-AD form 100 (DEU) (Employee's Disability Questionnaire)(See, 8 Cal. Code Regs. §§ 10160 and 10161) prior to the examination.

Declaration of Service

I declare that I am a resident of or employed in the county where the mailing took place. I am over the age of eighteen years and I am not a party to this case, my business or residence address is:

13160 Mindanao Way, Suite 310, Marina del Rey, CA 90292

On_____, I served this QME Appointment Notification Form, the original, or a true and correct copy of the original, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

A	depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.
B	placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.
C	placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.
D	placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*
E	personally delivering the sealed envelope to the person or firm named below at the address shown below.

Method of Service	Person or firm served	Street Address	City	State	Zip Code
B					
B					
B					
B					

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:_____ at Marina del Rey , California.

Type or print name Simon Lee

Signature Simon Lee

ORTHOLEGAL PRACTICE RULES & POLICIES

By requesting service as a Qualified Medical Evaluator in an initial evaluation, re-evaluation, supplemental report, or deposition, both parties agree to comply with the following:

EVALUATIONS/RE-EVALUATIONS

- OrthoLegal must be provided current demographic information and the Panel upon requesting an appointment. One or both parties must notify OrthoLegal of changes to the demographic information as they occur or upon future correspondence.
- Insurance carrier or their counsel must provide billing policies and procedures prior to the completion of the evaluation unless otherwise notified by OrthoLegal staff.
- OrthoLegal reserves its right to administratively re-schedule evaluations at its discretion. OrthoLegal will notify both parties via written and electronic communication if such a re-scheduling occurs.
- No additional individuals are allowed to attend the evaluation suite and examination room beyond the injured worker and the interpreter. No children or other dependents will be allowed into the evaluation suite, even if childcare arrangements could not be made. Family members or other associates may be allowed if they medically assist or are otherwise required to assist the completion of the evaluation but there is no guarantee that they will be permitted to be present during the examination and may not provide interpretation services
- **Duration of an evaluation is up to 4-6 hours from the scheduled start time. Bringing w ater and a snack are recommended; if applicants leave the evaluation site their evaluation will be considered a failed appointment.**
- **Applicants should be advised to continue their usual medications on the date of evaluation to avoid a medical emergency requiring care.**

PAYMENTS

- All payments of fees must be paid by check. No other means of payment, including Virtual Credit Card (VCC), POS Card, etc. will be accepted.

INTERPRETING

- If the injured worker is not fluent in the English language, the employer's attorney or insurance carrier and their counsel **must furnish** a certified interpreter in the injured worker's fluent language.
- One or both parties must provide the name and contact information of the interpreter when that information becomes available and ahead of the appointment.
- The interpreter must not interfere with the doctor's ability to conduct the evaluation, disrespect, or abuse the doctor and his/her staff. The evaluation may be marked failed for interference or unprofessional conduct of the interpreter.
- If either party fails to provide an interpreter, the administrative staff will attempt to utilize an available certified interpreter present provided to another injured worker without notice. If one is available, the parties consent to using that available interpreter and to be billed by their vendor.

CANCELLATIONS

- The elected Qualified Medical Evaluator and his/her administrative staff may administratively cancel and re-schedule an evaluation should the need arise. The parties will not be billed a no-show fee for an administrative cancellation or re-scheduling.
- If one party objects to the setting of the appointment more than **6 business days** from the date of the evaluation, the parties will not be billed a no-show/cancellation fee.
- The parties will be billed a cancellation/no-show fee in the event of:
  - Failure of the injured worker to appear at the scheduled date/time and location for his/her evaluation.
    - We request that the injured worker and interpreter check in 1 hour before the evaluation start time for check-in and paperwork.
    - The injured worker will be marked a "no-show" by the medical staff if they fail to appear after **30 minutes** past the scheduled start time.
    - If the injured work fails to notify the medical staff of tardiness on the date of the evaluation, late arrivals are not guaranteed to be accommodated and would be the same as a failure to appear.
    - For the safety of other applicants and our staff, applicants will be rescheduled and considered an untimely cancellation if they have upper respiratory symptoms or other symptoms of communicable disease.
    - If a booked interpreter appears at the evaluation but leaves before the evaluation has completed, the evaluation will be deemed a failed appointment subject to a cancellation/no- show fee.
    - One or both parties request that the evaluation be cancelled within **6 business days** of the date of the scheduled evaluation.
    - One party objects to the evaluation or scheduling the evaluation within **6 business days** before the date of the evaluation. (LC §9795)
  - The cancellation fee of **$503.75** per Labor Code §9795 will be billed to the parties and is expected to be paid should the parties agree to continue using the selected Panel Qualified Medical Evaluator.

DEPOSITIONS

- If the parties wish to depose the Qualified Medical Evaluator, the doctor's deposition fees are **$910.00** and must be received by OrthoLegal no less than 2 weeks before the date of the deposition. If no payment is received by that date, the deposition will be administratively cancelled.
- All payment instructions for deposition fees will be provided by OrthoLegal at the time of scheduling, including untimely cancellations which will incur the maximum allowable fee.

These rules and practices are subject to change. OrthoLegal will attempt resolution of an issue with the above rules to an amicable and reasonable standard on a case-by-case basis, but this is not guaranteed.

OrthoLegal has complied with all rules, regulations, and timely served its reporting, OrthoLegal reserves its right to seek all remedy to recover its lost costs and fees, including but not limited to, seeking WCAB intervention as a medical- legal cost petitioner.