## STATE OF CALIFORNIA

## Division of Workers Compensation - Medical Unit P.O. Box 71010, Oakland, CA 94612 (510) 286-3700 er (800)-794-6900

## QUALIFIED MEDICAL EVALUATOR'S FINDINGS SUMMARY FORM UNREPRESENTED INJURED EMPLOYEE CASES ONLY

EMPLOYEE								
Tiffany Anderson 549-23-5133						6/29/2011		
1. Employee Name (First, Middle, Last) 2. Social Se			c No (Optional)			3. Date of Injury (Mo/ Dy /Yr)		
2 N Avena Ave	Lodi, CA		95240 Zip			(209) 625-8575 5. Phone		
4. Street Address	City							
CLAIMS ADMINISTRATOR (if none, enter	Employer information)							
AIMS ACCLAMATION INSURANCE MANAGE	EMENT SERVICES							
6. Name								
P.O. Box 269120	Sacramento, CA		95826-9120		(916) 563-1900			
7. Street Address	City		Zip		1	8. Phone	e	
EVENT DATES								
12/29/2011	3/27/2012			1113		3.4		
9. Date of Appointment Call	ointment Call 10. Date of initial Examination 11. Date of Referra				Date of Referral	l for Medical Testing/Consultation		
12. Date AME/QME's Report Served on all Parties 12b. Date(s) of all parties					prior report(s) served by this QME?			
a. Has the condition reached perstatus or maximum medical in b. Is there permanent impairmed. Did work cause or contributed. If permanent disability exists apportionment warrented?  e. Is there a need for current or f. Can this employee now return If yes:  i. Without restrictions.	improvement? ent/disability? te to the injury or illness? s, is future medical care? en to his/her usual job?			No No	If YES, Date:	Yes Wes	No IIII	Pending or Info. Not Sent
BASIS FOR CONCLUSIONS  14. Are there subjective complete the subjective comple	ysical or psychological					(Check	No	Pending or Info. Not Sent
16. Are impairments described and measured using:  (For non-psyche injuries) the AMA Guides?  (For psyche injuries) the GAF and 2005 PD Schedule?								