STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT
MAILING ADDRESS:
P. O. Box 71010
Oakland, CA 94612
(510) 286-3700 or (800) 794-6900 Fax: (510) 622-3467

QME APPOINTMENT NOTIFICATION FORM

To the Qualified Medical Evaluator: You are required by law to give notice on this form when an appointment has been made with you to perform a QME comprehensive medical evaluation. Please complete this form in its entirety. You are legally required to include: the name and address of the employee, the name of the employer and claims administrator, and the appointment time and date. The Administrative Director also 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 evaluation. You also must use this form if you refer the injured worker for a consultation to advise the parties of the date and time of the appointment with the consulting physician (See, 8 Cal. Code Regs. § 32). 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 and 41(a)(7) and (a)(8)).

EMPLOYEE INFORMATION

NAME: **Tiffany Anderson**

ADDRESS: **2 North AVena Avenue, Lodi CA 95240**
City *State* *Zip*

PHONE: **(209) 948-7757** SOCIAL SECURITY No.: _____
(Social Security Number is for record-keeping purposes only.)

DATE OF INJURY: **06/19/2009** PANEL No.: **1522183** CLAIM/CASE No.: **V80700184**

EMPLOYER INFORMATION

NAME: **San Joaquin County MVCD**

ADDRESS: _____
City *State* *Zip*

PHONE: _____

CLAIMS ADMINISTRATOR INFORMATION

NAME: **Karen Jellison**

COMPANY: **AIMS**

ADDRESS: **PO Box 269120 Sacramento CA 95826**
City *State* *Zip*

PHONE: **(916) 563-1900**

APPOINTMENT INFORMATION

DATE OF APPOINTMENT CALL: **07/23/13** DATE OF APPOINTMENT: **10/24/13** TIME OF APPOINTMENT: **2:00 pm**

LOCATION OF APPOINTMENT: **8801 Folsom Blvd., Suite 105, Sacramento CA 95826**

CERTIFIED INTERPRETER REQUIRED: (LANGUAGE) _____

COPY TO: ☑ EMPLOYEE (and employee's attorney, if known)

☑ CLAIMS ADMINISTRATOR (and attorney, if known)

SIGNATURE OF QME: _____

QME NAME (print/type): **Thomas S. Allems MD MPH** **415.989.5339**

ADDRESS AND PHONE: **311 California Street, Suite 310, San Francisco CA 94104** **MAIL**

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.

$250 IS CHARGED FOR A NO SHOW OR A CANCELLATION WITHIN 5 BUSINESS DAYS

THE FACE OF THIS DOCUMENT HAS A MULTI-COLORED BACKGROUND ON WHITE PAPER

No. 0000016616

Vector-JPA
Administered By: Acclamation Insurance Management Services
P.O. Box 269120
Sacramento, CA 95826

Date: 10/11/2013

11-204/1210
California Bank & Trust
Sacramento Main Office
1331 Broadway Sacramento CA 95818

PAY NINETEEN DOLLARS AND 49 / 100**

$********** 19.49**

VOID AFTER 60 DAYS

TO THE ORDER OF

TIFFANY ANDERSON
2 N. AVENA AVE.
LODI, CA 95242

RUB RED IMAGE FADES WITH HEAT

SECURITY FEATURES INCLUDED. DETAILS ON BACK.

⑈00000166 16⑈ ⑆121002042⑆ 10300 7496 1⑈

Vector-JPA
P.O. Box 269120 Sacramento, CA 95826 - Phone: DPW FAX:

Remitted to	Vendor ID	Check Number	Date	Internal Reference	Total Remitted	Page 1
TIFFANY ANDERSON		0000016616	10/11/13		$19.49	

Claim No: VE0700184 **Name:** Anderson, Tiffany **Date of Loss:** 06/19/2008

Service Period: 10/24/2013 - 10/24/2013 **Payment Type:** Mileage **Comments:** / mileage for appt with Dr. Allems

TOTAL REMITTANCE **$19.49**

Knee Injury #1 date

WARNING: You are required to report to your employer or the insurance company any money that you earned for work during the time covered by this check, and before cashing this check. If you do not follow these rules, you may be in violation of the law and the penalty may be jail or prison, a fine, and loss of benefits.
ADVERTENCIA: Es necesario que usted le avise a su patron o a su compania de seguro todo dinero que usted ha ganado por trabajar, durante el tiempo cubierto por este cheque, y antes de cambiar este cheque. Si usted no sigue estos reglamentos, Usted puede estar en violacion de la ley y el castigo podria ser carcel o prision, una multa, y perdida de beneficios.