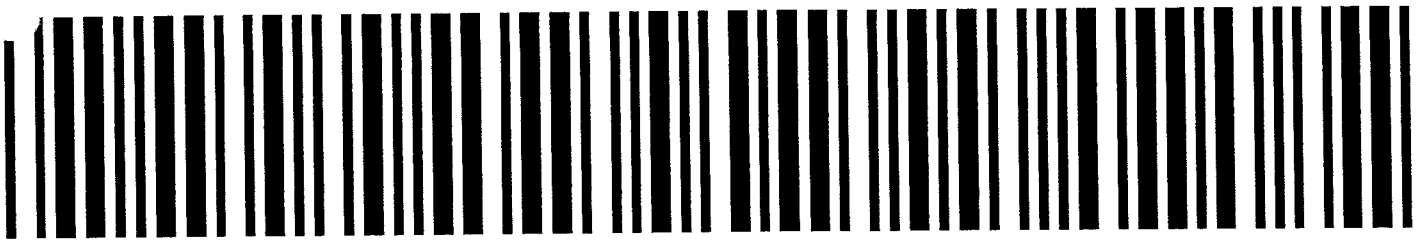
5-9-16

DOCUMENT SEPARATOR SHEET



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STATE OF CALIFORNIA
Division of Workers' Compensation – Medical Unit
P.O. Box 71010, Oakland, CA 94612
(510) 286-3700 or 1 (800) 794-6900

QME or AME Conflict of Interest Disclosure Form

QME/AME Name: Khosrow Tabaddor

Injured Employee Name: Tiffany K. Anderson

Claims Administrator: Nancy Urton

Claim No.: VE0700184 **EAMS or WCAB Case No. (if known)** ADJ7004221, +

QME Panel No. (if applicable):

Date Scheduled for Medical/Legal Examination: 5-9-2016

NOTICE TO THE PARTIES: (check appropriate box)

☐ **I, the undersigned evaluator, have determined I have a disqualifying conflict of interest as defined in section 41.5 of the QME regulations (8 Cal. Code Regs.) in this case.**

Person/Entity with whom conflict exists:

_____

Category of Conflict: (check one or more)

- ☐ familial
- ☐ professional
- ☐ significant financial
- ☐ other (describe):

_____

☐ **I have reviewed the information sent by** _____ **regarding an alleged conflict of interest. I do not believe that any disqualifying conflict of interest, as defined in 8 Cal. Code Regs. § 41.5, exists.**

I declare under penalty of perjury of the laws of California that the foregoing is true and correct to the best of my knowledge. Signed this day : _____ (MM/DD/YYYY)

_____ (Print Name) _____ (Signature)

Objection or Waiver By Represented Parties

I wish to (check one):

- ☐ **Object to the Evaluator due to the conflict**
- ☐ **Waive the conflict and continue using the QME/AME in this case in spite of this conflict.**

_____ (Date signed)

_____ (Print Name of Party or Attorney Signing) _____ (Signature)

If form signed by attorney, name of party: _____