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STATE OF CALIFORNIA
Division of Workers' Compensation
Disability Evaluation Unit

EMPLOYEE'S DISABILITY QUESTIONNAIRE

DEU Use Only

This form will aid the doctor in determining your permanent impairment or disability. Please complete this form and give it to the physician who will be performing the evaluation. The doctor will include this form with his or her report and submit it to the Disability Evaluation Unit, with a copy to you and your claims administrator.

Employee

First Name _____ MI ____

Last Name _____

SSN (Numbers Only) _____

Street Address 1/PO Box (Please leave blank spaces between numbers, names or words) _____

Street Address 2/PO Box (Please leave blank spaces between numbers, names or words) _____

International Address (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Date of Birth _____
MM/DD/YYYY

Date of Injury _____
MM/DD/YYYY

Employer _____

Nature of Employers Business _____

Claim Number 1 _____

Claim Number 2 _____

Claim Number 3 _____

Claim Number 4 _____

Claim Number 5 _____

PLEASE ANSWER THE FOLLOWING QUESTIONS FULLY:
How was your evaluating doctor selected? (check one)

☐ From a list of doctors provided by the State of California, Division of Workers' Compensation.

☐ Other (explain) _____

What is the name of the doctor who will be doing the evaluation? _____

When is your examination scheduled? _____

What were your job duties at the time of your injury?

What is the disability resulting from your injury?

How does this injury affect you in your work?

Have you ever had a disability as a result of another injury or illness? _____

If so, when? _____

Please describe the disability?

Date _____ MM/DD/YYYY

Signature _____