SAN FRANCISCO OFFICE

525 GOLDEN GATE AVENUE
SAN FRANCISCO

MAIL ADDRESS: P.O. BOX 603
SAN FRANCISCO 94101-0603

PLEASE SEND TWO COPIES

STATE OF CALIFORNIA
Department of Industrial Relations
Division of Industrial Accidents

DISABILITY EVALUATION BUREAU

LOS ANGELES OFFICE
LOS ANGELES STATE OFFICE BUILDING
107 SOUTH BROADWAY
LOS ANGELES 90012-4578

EMPLOYEE'S REQUEST FOR INFORMAL PERMANENT DISABILITY RATING

This form should be completed and submitted as soon as the permanent effects of the injury appear stationary.

IMPORTANT - **This is not a request for a Hearing or an Award. This will not prevent the operation of the Statute of Limitations.**

EMPLOYEE ______________________
(Please Print)

Social Security No. ______________________

Address ______________________
(Street and Number, or Rural Route)

____
(City) (ZIP Code)

Date of injury ______________________
(Month) (Day) (Year)

Age (give date of birth) ______________________
(Month) (Day) (Year)

Occupation (at time of injury) ______________________

Have you returned to work? ________ Date ______________

EMPLOYER ______________________

Address ______________________
(Zip Code)

Nature of employer's business ______________________

____

____

Employer's Workers' Compensation Insurance Carrier:

____

____

Have you ever sustained any other permanent disability? ____ If so, when? ______________________

What was its nature? ______________________

PLEASE ANSWER FOLLOWING QUESTIONS FULLY, using reverse side if needed.

What were the general duties of your job when you were injured?

What is your disability resulting from this injury?

How does this disability affect you in your work?

Sign here ______________________ Date ______________