State of California
DIVISION OF WORKERS' COMPENSATION – MEDICAL UNIT

ADDITIONAL PANEL REQUEST

TITLE 8, CALIFORNIA CODE OF REGULATIONS § 31.7
(*Please print or type*)

If anything has changed including parties, addresses, and represented status, Please attach the information on a separate sheet of paper

Date of Request: *(Required)* ____________

Original Panel Number: (*Required*) ________________________

Requesting Party: (*Check one box only*)

- ☐ Applicant's Attorney/Injured Worker
- ☐ Defense Attorney/Claims Administrator
- ☐ Joint Request

Claim Number: *(Required)* __________________

Injured Worker: *(Required)*

__________________ First Name

__________________ Last Name

Specialty (ies): (*Required*) **(Use the three-letter code)**

________________ ________________ ________________

Reason for Additional Panel (all references are to Title 8, CCR 31.7 unless otherwise noted):

- ☐ Judge's Order (Please attach a copy of the order). (b)(1)
- ☐ The AME or QME selected advised the parties and Medical Director there are issues which need to be addressed that are outside his or her clinical competence. (Please attach copy of AME/QME report) (b)(2)
- ☐ A written agreement between the parties in a represented case. (Please attach a signed joint letter or jointly sign the bottom of this form) (b)(3)
- ☐ Agreement of the parties and an Information and Assistance Officer in an unrepresented case. (Please attach I&A recommendation or have I&A Officer sign on the line below) (b)(4)

Name of Requestor (Print) __________________

Requestor's Signature __________________

Name of Requestor (Print) __________________

Requestor's Signature __________________

Name of I&A Officer (Print) __________________

I&A Officer's Signature __________________