

California Orthopaedic Association Supplemental Report Template

While the Division of Workers' Compensation (DWC) is not mandating the use of this template for your Supplemental Reports, COA strongly recommends that you prepare your Report in this order and with these topic headings.

1. To improve the completeness of your Supplemental Reports;
2. To help parties find information in your report; and,
3. To ensure that you have addressed all the required elements.

Put on your Letterhead

(Date of Report)

(List Names & Address/Fax/Email of Report Recipients – Carrier and Attorneys)

Identifying Information Injured Worker

RE: (Name of Injured Worker)
DOB: (Date of birth of Injured Worker)
DOI: (Date of Injury(s))
EMP: (Name of Employer)
Claim#: (List Claim Number(s))
WCAB#: (List WCAB Number(s))
DOE: (List Date of Initial Evaluation)

Supplemental Report Requested by: (List Who Requested Supplemental Report)
[Supplemental Reports can be requested by the defense, a workers' compensation judge, the Appeals Board, or applicant attorney.]

Date Supplemental Report Request was received: (List date)

Evaluator Status

Identify your status: QME ____ AME ____

Is this supplemental report a result of a requested re-examination of the patient?

YES ____ NO ____

AME or QME (list whichever is appropriate)
Requested Supplemental Report and Record Review

Dear Parties:

I have been requested to submit a supplemental report for (Name). I reviewed ____ pages of new records which were forwarded to me by the parties with proper statements under penalty of perjury in of compliance with Labor Code 4062.3 and an attestation as to the number of pages sent. The total number of pages I received less 50 pages was _____ pages. This is /is not consistent with the attestation of pages by the parties.

Medical Record Review:

Chronically list a summary of medical records reviewed.

Date Provider name, medical specialty, and name of medical center (if applicable)
Summarize medical record.

Date Provider name, medical specialty, and name of medical center (if applicable)
Summarize medical record.

Indicate if supplemental report is due to a request from your deposition, if so state the date of the deposition and the number of pages reviewed of the deposition transcript to prepare this report: _____

Discussion:

State what you have been asked to address in the Supplemental Report.

Bullet point and address in specific detail, each question that is in the Supplemental Report request.

Examples of issues you may be asked to address include:

1. Review and comment on additional medical records/x-rays/diagnostic test results.
2. Comment on a new body part accepted as part of the work-related injury as a result of your Initial evaluation.
3. Clarification on causation.
4. Clarification on apportionment.
5. Any other issue in your report/evaluation that needs clarification or to be addressed.

In your discussion, state whether the additional information provided to you/question you were asked changes your orthopaedic opinion in regard to this evaluation. Be specific. Cite the new medical record(s) sent to you that changed your opinion. It may be appropriate to comment on whether the new information affects the issue of cumulative trauma, causation or impairment for the body parts that were injured as part of the industrial claim.

Reason(s) for Opinion:

Language you might want to consider:

The history and physical examination of the patient combined with a review of any available medical records and discussion of the patient's condition form the basis of this report.

(Optional) If there are any questions at all regarding the patient, please do not hesitate to call me directly.

Disclosure Statement:

It is mandatory that you must include this Disclosure Statement:

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

I further declare under penalty of perjury that I have not violated the provisions of California Labor Code Section 139.3 with regard to the evaluation of this patient or the preparation of this report.

I further declare under penalty of perjury that the names and qualifications of each person who performed any services in connection with the report, including diagnostic studies, other than clerical preparation, are as follows:

(List names or "None" if all services were performed by you)

Executed on: _____ in the County of _____, California.

Sincerely,

Name/Address of QME/AME

(The Supplemental Report should be sent to all parties.)

PROOF OF SERVICE (retain a copy in the IW's file)

The undersigned declares:

1. I am an employee in the County of _____, State of California, working at the office of (name and address of QME/AME)

2. I am over the age of eighteen (18) and not a party to this action.
3. On ___/___/2024 I served the following document(s) as hereinafter described:

SUPPLEMENTAL REPORT RE: (name of injured worker)

4. I placed a true and correct copy of the foregoing document(s) in a sealed envelope addressed to the following:

(Name and address of each attorney/injured worker to whom the report was sent)

(Name of carrier and claims adjuster and the address to whom the report

was sent)

5. I then placed said envelopes for collection, processing, and mailing in the mailbox of the United States Postal Service on today's date, following the ordinary business practices of (name of QME/AME).
6. Pursuant of these practices, with which I am readily familiar, sealed, addressed envelopes are deposited in the ordinary course of business with the United States Postal Service the same date they are collected and processed with postage thereon fully prepaid, declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on / /2024, (City) , California

Signature