CC-FORM-M

WORKERS' COMPENSATION COMMISSION

REQUEST FOR APPOINTMENT OF INDEPENDENT MEDICAL EXAMINER, REHABILITATION EVALUATOR, OR MEDICAL CASE MANAGER

COMMISSION FILE NO.	Claimant's Social Security No. (LAST 4 DIGITS ONLY) XXX-XX-_____
Full Name of Claimant (Injured Employee)	
Claimant's Mailing Address	
City State Zip Code	
Claimant's Date of Birth	Claimant's Telephone Number ( )
IME Requested By: ☐ Claimant ☐ Respondent ☐ Commission ☐ Mutual Agreement	

THIS SPACE FOR COMMISSION USE ONLY: Revised 4-7-14
☐ IME Physician ☐ Rehabilitation Evaluator ☐ Medical Case Manager
BODY PARTS
Name of Respondent (Employer)
Name of Insurer
Date of Injury
IME Physician Selected By: ☐ Parties ☐ Commission

Issues:

1.____Is the claimant currently temporarily totally disabled?

2.____Was claimant temporarily totally disabled from _____ to _____?

3.____Is claimant in need of additional medical treatment? Treatment is not authorized.

4.____Physician is requested to make specific recommendations regarding treatment.

5.____Does claimant need pain management?

6.____Does claimant need continuing medical maintenance?

7.____In relation to an objection to termination of temporary total disability, is the claimant in need of further medical treatment? Physician is to make specific recommendations regarding the reasonableness and necessity of further medical treatment. Treatment is not authorized unless agreed upon by the parties.

8.____Is the surgery that is recommended by the treating physician reasonable and necessary?

9.____Is the claimant's medical treatment recommended care under the Work Loss Data Institute's *Official Disability Guidelines* (ODG) or the Physician Advisory Committee Guidelines (PACG)?

10.____If treatment is not needed, or if claimant has reached maximum medical improvement, physician is to rate the nature and extent of permanent partial disability, if any.

11.____Physician is requested to determine causation of claimant's complaints. If determined to be work-related, then: *(identify issues)* _____.

12.____Physician is requested to address the issue of apportionment, if applicable.

13.____Physician to determine if the claimant has suffered a change of condition for the worse.

14.____Physician to determine if the claimant is permanently and totally disabled.

15.____Physician is directed to review a videotape which shall be provided by the respondent. The cost of the physician's review shall be borne by the respondent in accordance with Commission Rule 810:15-9-5. After reviewing, the physician shall address: *(identify issues)* _____

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16.____Physician to determine if the claimant is permanently and totally disabled as a result of the combination of injuries.

17.____Physician to address if vocational rehabilitation is indicated (i.e. whether as a result of the injury the claimant is unable to perform the same occupational duties the claimant was performing before the injury).

18.____Counselor is to perform rehabilitation evaluation, including recommendation for vocational retraining plans, if appropriate.

19.____Counselor is to determine transferable skills.

20.____Counselor is to provide job placement assistance.

Authorizations:

1. _____Diagnostic testing that is reasonable and necessary to respond to the issues specified in this order is authorized.

2. _____Other: _____

Special Instructions: _____

_____

_____

_____ Claimant/Claimant Attorney, if represented OBA#	_____ Administrative Law Judge
_____ Opposing Party/Counsel OBA#	_____ Date