

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-XXXX
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: <input type="checkbox"/> Claimant <input type="checkbox"/> Respondent <input type="checkbox"/> Commission <input type="checkbox"/> Mutual Agreement	

THIS SPACE FOR COMMISSION USE ONLY: Revised 12 18 14	
NAME OF: <input type="checkbox"/> IME Physician <input type="checkbox"/> Rehabilitation Evaluator <input type="checkbox"/> Medical Case Manager	
BODY PARTS	
Name of Respondent (Employer)	
Name of Insurer	
Date of Injury	
IME Physician Selected By: <input type="checkbox"/> Parties <input type="checkbox"/> 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)* _____.
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