

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 5 DIGITS ONLY) XXX-X
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:		
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