

**ORS 656.325 (1)(a),(f)**  
**OAR 436-060-0095 Suspension Checklist**  
Chapter 436, Division 060, Claims Administration, effective April 1, 2011  
**FAILURE TO ATTEND OR TO COOPERATE WITH AN IME**

Claimant \_\_\_\_\_ Claim Number \_\_\_\_\_

Claim status: \_\_\_\_\_Deferred \_\_\_\_\_Accepted \_\_\_\_\_Denied \_\_\_\_\_Partial Denial

**IME APPOINTMENT LETTER**

1. \_\_\_\_\_ IME examiner chosen from director's list *OAR 436-010-0265(1)*
2. \_\_\_\_\_ On insurer letterhead if party other than insurer schedules exam *0095(4)*
3. \_\_\_\_\_ Worker notified in writing; appointment notice sent at least 10 days prior to exam  
*0095(5)*
4. \_\_\_\_\_ If represented, worker's attorney simultaneously notified in writing *0095(5)*
5. \_\_\_\_\_ Name of the examiner or the facility *0095(5)(a)*
6. \_\_\_\_\_ Statement of specific purpose for exam and identification of medical specialties of examiners *0095(5)(b)*
7. \_\_\_\_\_ Date, time, and place of exam *0095(5)(c)*
8. \_\_\_\_\_ First and last name of Attending Physician (AP) or Authorized Nurse Practitioner (ANP) and verification AP or ANP is being informed of the exam by at least a copy of the appointment letter, OR a statement that there is no AP or ANP *0095(5)(d)*
9. \_\_\_\_\_ If applicable, confirmation that the director has approved the examination *0095(5)(e)*
10. \_\_\_\_\_ Reasonable costs for transportation and, if necessary, child care, meals, lodging, and other related services will be reimbursed with receipts or other evidence necessary to support request *0095(5)(f)*
11. \_\_\_\_\_ Offer advance of funds and that a request must be made in sufficient time to assure attendance at exam *0095(5)(f)*
12. \_\_\_\_\_ That an amount equivalent to net lost wages will be paid for absence from work necessary to attend exam if temporary disability is not received under ORS 656.210(4)  
*0095(5)(g)*

13. \_\_\_\_\_ That the worker has the right to have an observer present at the exam, but the observer may not be compensated in any way for attending the exam. If the exam is psychological, the observer is allowed only if the examining provider approves the presence of an observer *0095(5)(h)*

14. \_\_\_\_\_ The boldface or prominent warning paragraph *0095(5)(i)*:

**“You must attend this examination. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the examination. If you fail to attend and do not have a good reason for not attending, or you fail to cooperate with the examination, your workers’ compensation benefits may be suspended in accordance with the workers’ compensation law and rules, ORS 656.325 and OAR 436-060. You may be charged a \$100 penalty if you fail to attend without a good reason or if you fail to notify the insurer before the examination. The penalty is taken out of future benefits.**

**If you object to the location of this appointment you must contact the Workers’ Compensation Division at 1-800-452-0288 or 503-947-7585 within six business days of the mailing date of this notice. If you have questions about your rights or responsibilities, you may call the Workers’ Compensation Division at 1-800-452-0288 or 503-947-7585 or the Ombudsman for Injured Workers at 1-800-927-1271.”**

15. \_\_\_\_\_ Include the following with the IME appointment notice sent to the worker *0095(6)*:

- A copy of a reimbursement request form *0095(6)(a)*
- director’s brochure “Important Information about Independent Medical Exams” *0095(6)(b)*

### **SUSPENSION REQUEST**

1. \_\_\_\_\_ Copy of the suspension request, including all attachments, sent certified, registered, or by personal service to the worker *0095(8)*
2. \_\_\_\_\_ If represented, a copy of the suspension request, including all attachments, simultaneously sent certified, registered or by personal service to the worker's attorney *0095(8)*
3. \_\_\_\_\_ A statement that the insurer requests suspension of benefits pursuant to ORS 656.325 and OAR 436-060-0095 *0095(8)(a)*
4. \_\_\_\_\_ Identify the claim status and any accepted or newly claimed conditions *0095(8)(b)*
5. \_\_\_\_\_ Describe the worker's specific actions or inactions that prompted the request *0095(8)(c)*
6. \_\_\_\_\_ Dates of prior IMEs the worker has attended for the current open period of this claim and the names of examining physicians or facilities OR a statement that there have been no prior IMEs *0095(8)(d)*
7. \_\_\_\_\_ A copy of any approval given by the director OR a statement that approval was not necessary *0095(8)(e)*

8. \_\_\_\_\_ Any reason given by the worker or the worker's representative for failure to comply OR a statement that no reason has been provided **0095(8)(f)**
9. \_\_\_\_\_ The date and with whom the failure to comply was verified. Written verification of the worker's refusal to attend exam received from worker or worker's attorney is sufficient to request suspension. **0095(8)(g)**  
e.g. "On \_\_\_\_\_(date) \_\_\_\_\_(name) at \_\_\_\_\_(facility) verified the worker did not attend" OR "On \_\_\_\_\_(date) \_\_\_\_\_(insurer) received written verification from \_\_\_\_\_(worker or attorney) stating that the worker would not be attending the exam"
10. \_\_\_\_\_ A copy of the IME notice of appointment letter and a copy of any written refusal to attend received from the worker or worker's attorney **0095(8)(h)**
11. \_\_\_\_\_ Any other supporting information that supports suspension request **0095(8)(i)**
12. \_\_\_\_\_ The boldface or prominent notice to worker **0095(8)(j)**:

**"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the mailing date of this request. If the division grants this request, you may lose all or part of your benefits. If your claim has not yet been accepted, your future benefits, if any, will be jeopardized."**