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| http://inside.cbs.state.or.us/docs/branding/logos/wcd/en/JPEG/WCD-logo-black.jpg |  | Insurer’s Request for Director Approval of an AdditionalIndependent Medical Examination |
| Worker information |  |
|  |
| Worker name: |  | Phone: |  |
| Address: |  |
| Date of injury: |  | Insurer: |  | Claim no.: |  |
|  |
| INDEPENDENT MEDICAL EXAMINATION (IME) INFORMATION |  |
|  |
| 1. | State the reasons you are requesting an additional IME and the conditions you want to have evaluated. **Note:** Include any medical documentation you want to have considered in this matter. *(Use the back of this form or attach additional sheets, if necessary.)* |
|  |  |
| 2. | What was the date of the last IME to evaluate this condition? Date: |  |  |
| 3. | How many IMEs has the worker attended since the claim was last opened? |  |
| 4. | Attach copies of previous IME notification letters for this open period. If you **cannot** provide copies, list all examinations in chronological order, with the names of the examiners, time, date, place, and conditions evaluated. *(Use the back of this form or attach additional sheets, if necessary.)* |
|  |  |
| 5. | What was the purpose of the previous IMEs? |
|  |
| Certification statement |  |
|  |
| By signing below, I certify that I: |
| * Have answered all questions to the best of my ability.
 |
| * Have attached sufficient documentation to support the request (See [Bulletin 252](https://wcd.oregon.gov/Bulletins/bul_252.pdf)).
 |
| * Will provide a copy of this request to the worker and the worker’s attorney (if represented).
 |
|  |
| Signature: |  | Date: |  |
| ***Send a completed and signed copy of this form and all accompanying documents to:*** Workers’ Compensation Division, Medical Resolution Team  350 Winter St. NE, P.O. Box 14480 Salem, OR 97309-0405 |
| Notice to the worker |  |
|  |
| If you object to the request for an additional independent medical examination (IME), send your objections within 10 days from the date of this request to: Workers’ Compensation Division, Medical Resolution Team 350 Winter St. NE P.O. Box 14480 Salem OR 97309-0405The director will approve or deny the insurer’s request based only on available information.***For more information, contact the Medical Resolution Team at* 503-947-7606*, email*** ***wcd.medicalquestions@dcbs.oregon.gov******, or visit our website:*** [***www.wcd.oregon.gov***](http://www.wcd.oregon.gov)***.*** |
| 440-2333 (6/25/DCBS/WCD/WEB) |