Independent Medical Examination Scheduling Form

Case Data

Field			
Your Company's Name			
Your Name			
Your Telephone Number			
Claimant Name			
Claim No./Soc. Sec. No./Case No.			
Employer			
Date of Injury			
Allowed Conditions			
Purpose of Evaluation			
Date for Scheduled Exam			
Hearing Date (if applicable) ***RUSH?***			

Type of Examination

Please complete this form by checking all appropriate boxes.

☐	Extent of Disability
	☐ Maximum Medical Improvement
	☐ Necessity of Additional Treatment
	☐ Appropriateness of Treatment Provided to Date
	☐ Return to Work and/or Work Restrictions
	☐ Temporary Total Disability
☐	Allowance (Claim is Being Contested)
☐	Additional Allowance (Claimant has requested additional allowance) **Please list allowances being requested:**
☐	Percentage of Permanent Partial Impairment
☐	Permanent Total Disability

<u>Special Instructions</u>:

26016 Detroit Road Westlake, OH 44145 Telephone 440 250 0424 Facsimile 440 250 0429