

RETURN TO:
 OFFICE OF WORKERS' COMPENSATION, ATTN: Medical Services
 POST OFFICE BOX 94040
 BATON ROUGE, LA 70804-9040
 (225) 342-7559
 TOLL FREE (800) 201-2494

1. Social Security No. _____ - _____ - _____
2. Date of Injury/Illness _____ - _____ - _____
3. Part(s) of Body to be evaluated _____
4. Date of Birth _____ - _____ - _____
5. OWC Docket Number _____
6. OWC District Number _____
7. Claim # _____

REQUEST FOR INDEPENDENT MEDICAL EXAMINATION

NOTE: THIS REQUEST WILL NOT BE HONORED
 UNLESS A DISPUTE HAS ARISEN AS TO
 CONDITION OF THE EMPLOYEE AS PER L.R.S. 23:1123.

8. This form is submitted by:
- Employee
 Employer
 Insurer
 TPA/Self Insurance Fund

- A. The choice of the medical practitioner shall be that of the Director of the Office of Workers' Compensation as per L.R.S. 23:1123.
- B. A cover letter outlining the conflicting medical issue(s) in dispute (reason for request) along with the conflicting medical reports must be attached to this form.
- C. A list of names, addresses, phone numbers and reports of all physicians/medical providers who have treated or examined the injured employee for this injury must be included. Indicate who chose each health care provider.
- D. A copy of this request must be **signed, dated and mailed** to all parties.

EMPLOYEE

EMPLOYEE'S ATTORNEY

9. Name _____
 Street or Box _____
 City _____
 State _____ Zip _____
 Phone () _____

10. Name _____
 Street or Box _____
 City _____
 State _____ Zip _____
 Phone () _____
 Fax () _____

EMPLOYER

**INSURER / ADMINISTRATOR
 (circle one)**

11. Name _____
 Street or Box _____
 City _____
 State _____ Zip _____
 Phone () _____

12. Name _____
 Adjuster Name _____
 Street or Box _____
 City _____
 State _____ Zip _____
 Phone () _____
 Fax () _____

**EMPLOYER / INSURER'S ATTORNEY
 (circle one)**

13. Name _____
 Street or Box _____
 City _____
 State _____ Zip _____
 Phone () _____
 Fax () _____

Signature of Applicant

Date