REQUEST FOR INDEPENDENT MEDICAL EXAMINATION

MAINE WORKERS' COMPENSATION BOARD
OFFICE OF MEDICAL/REHABILITATION SERVICES
27 STATE HOUSE STATION
AUGUSTA, ME 04333-0027
(207) 287-7062

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-	7. DATE OF BIRTH:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:	9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. EMPLOYEE ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY: / 13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. WCB FILE NUMBER:	
18. ADJUSTER NAME, PHONE AND EMAIL ADDRESS:			

NATURE OF INJURY:____

AGREED UPON INDEPENDENT MEDICAL EXAMINER? ☐ YES ☐ NO

IF YES, NAME, ADDRESS AND TELEPHONE: OF AGREED UPON EXAMINER:______________________________________

IF NO, HAS THERE BEEN AN UNSUCCESSFUL MEDIATION OR HAS A REQUEST FOR PROVISIONAL ORDER BEEN ACTED ON AND THE CASE IS PROCEEDING TO THE FORMAL HEARING LEVEL? ☐ YES ☐ NO

IF YES, PETITIONS PENDING:____

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PREFERRED SPECIALTY, IF ANY (NOTE:THE BOARD IS NOT BOUND BY SUCH PREFERENCE): ___________________________

QUESTIONS RELATING TO THE MEDICAL CONDITION OF THE EMPLOYEE (ATTACH A SEPARATE SHEET OF PAPER IF NECESSARY):

LIST ALL INTERESTED PARTIES AND WHOM EACH REPRESENTS (EE OR ER) (ATTACH A SEPARATE SHEET OF PAPER IF NECESSARY). NOTE: COPIES OF THIS DOCUMENT MUST BE MAILED OR DELIVERED TO ALL PARTIES LISTED HERE.

ER/EE:______ NAME: __________________________ CLIENT:____________________ ADDRESS: _______________________________ PHONE: __________________

ER/EE:______ NAME: __________________________ CLIENT:____________________ ADDRESS: _______________________________ PHONE: __________________

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ER/EE:______ NAME: __________________________ CLIENT:____________________ ADDRESS: _______________________________ PHONE: __________________

REQUESTER NAME, ADDRESS, TELEPHONE NUMBER AND EMAIL ADDRESS:	DATE MAILED:

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.