

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

INFORMATION REGARDING INDEPENDENT MEDICAL EXAMINATION

- I understand that I will be going to an independent medical examination (IME).
- I understand that the IME will be done by a doctor who is not giving me treatment or care, and that I will not have a patient/doctor relationship with this doctor. The doctor doing the IME is being paid by the employer or the insurer in my workers' compensation claim. The doctor will write a report about the exam, and I will get a copy of the report.
- I understand that the doctor will ask me questions about my condition and/or medical history, and may also look at my medical records.
- I understand that the doctor is required by law to make an audio (voice) recording of this examination. Therefore, what the doctor says and what I say may be heard by others at a later date and I should not have an expectation of privacy about things that are related to my workers' compensation claim.
- I understand that anyone involved in my claim, including me, can request a copy of the recording, and that if anybody makes a request the recording will first be given to me. I understand that if I say something during the examination that I believe is private and not related to my claim, there is a way for me to try to have that part of the recording erased.
- I understand that I have 20 days after the report is sent to me to ask, in writing, for a copy of the audio recording. I understand that the doctor is allowed to charge me \$20 for this copy. If I believe that part of the recording should be erased, I have to say it in writing within 15 days of when the recording was sent to me. I understand that information about the process is available by contacting the Division of Workers' Compensation and/or looking at its website. Anything that is mentioned in the doctor's written report will not be erased.
- I understand that I must be given this form, and that I must sign this form, according to a Division of Workers' Compensation Rule. I understand that refusing to sign this form may be determined to be a refusal to submit to an independent medical examination, and that such refusal could possibly impact my receipt of benefits.
- I understand that this form is intended to provide specific and limited information regarding the IME. I can seek additional information and/or legal advice if I so choose. I can also call the Division at 303-318-8700 or 888-390-7936 for additional information regarding Rule 8 requirements.

Signature

Print name

Date

For use by a language interpreter, if necessary

I, _____ (print name of interpreter) affirm that on this ____ day of _____, 20__, I read this document in its entirety to the individual whose name appears above in that person's native language, and that the person indicated an understanding of each and every provision contained on this form.

Signature