

COLORADO DEPARTMENT OF LABOR & EMPLOYMENT  
DIVISION OF WORKERS' COMPENSATION

**APPLICATION FOR “24 MONTH” DIVISION INDEPENDENT MEDICAL EXAMINATION (IME)  
REQUESTED PURSUANT TO C.R.S. 8-42-107(8)(b)(II)(A)-(D)**

**This form must be submitted to the Division and all parties by the requesting party when the statutory conditions for requesting a “24-Month” independent medical examination have been met.**

**If the requester wishes to cancel the IME process, notify the IME Section of the Division in writing.**

IME INFORMATION

1. Check the box for the party requesting the IME:      Claimant    Carrier
  
2. WC# \_\_\_\_\_ Carrier Claim # \_\_\_\_\_ Social Security # \_\_\_\_\_  
Claimant Name \_\_\_\_\_ Date of Injury \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_
  
3. \*Claimant’s Attorney \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_
  
4. Carrier Name \_\_\_\_\_
  
5. Adjuster Name \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_
  
6. Carrier’s Attorney \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_
  
7. If Agreed Upon IME Physician  
Physician \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_  
Address \_\_\_\_\_  
IME Appointment Date \_\_\_\_\_ Appointment Time \_\_\_\_\_
  
8. If Unable to Agree Upon IME Physician  
Preferred Location   1<sup>st</sup> Choice \_\_\_\_\_ 2<sup>nd</sup> Choice \_\_\_\_\_
  
9. List specific part(s) of the body and all conditions to be evaluated, including psychiatric where appropriate.  
\_\_\_\_\_  
\_\_\_\_\_
  
10. **The physician shall consider the following issues if relevant:** Maximum medical improvement, permanent impairment, and apportionment.
  
11. List any concerns to be addressed by the IME Physician (for example, further need for surgery).  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*If the claimant and/or insurer is/are represented by an attorney, all Division correspondence will be mailed only to the attorney(s) listed.

12. MEDICAL PROVIDER HISTORY

List name AND address of each physician who has evaluated or treated the claimant for this and/or any other relevant medical condition or injury. If a physician assigned an MMI date or an impairment rating, list the information. At least one MMI date must be listed for this "24 Month" IME to proceed. Attach additional pages, if needed. The Division and the IME physician use this information to assure there is no conflict of interest.

Physician Name	Physician Address (Street Address, City, State and Zip Code)	MMI Date	% Rating <i>if any</i> (WP or Extremity)

13. CERTIFICATE OF PAYMENT FOR IME

I hereby certify that I will be responsible for payment of the Division of Workers' Compensation Independent Medical Exam. I understand that this payment **MUST** be made to the selected physician's office at least ten (10) calendar days before the scheduled exam. **\*\*Check Here \_\_\_\_\_ if the claimant is the requester and has received a determination of indigence by order of an administrative law judge, or if an indigence proceeding is pending. If there has been an order granting indigence the insurance carrier or employer must advance the funds to pay for this IME, regardless of whether the claimant signs below.** It is requested that a copy of the judge's order be attached to this application.

By: \_\_\_\_\_  
Requester's Signature

\_\_\_\_\_  
Requester's Name

\_\_\_\_\_  
Requester's Address

14. CERTIFICATE OF MAILING: Copies of this document were placed in the U.S. mail or delivered to the following parties this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

List the names and addresses of all persons copied:

	Name	Address
Claimant:	_____	_____
Claimant's Attorney:	_____	_____
Carrier:	_____	_____
Carrier's Attorney:	_____	_____

Division of Workers' Compensation, 633 17<sup>th</sup> St., Suite 400, Denver, CO 80202-3660  
*(Send original document to the Division.)*

By: \_\_\_\_\_  
Signature

If you have any questions about the IME process, contact the Division of Workers' Compensation IME Unit.

Division of Workers' Compensation – IME Unit  
633 17th St., Suite 400  
Denver, CO 80202-3660  
Phone: 303.318.8655 / Toll Free: 888.390.7936