

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
 DIVISION OF WORKERS' COMPENSATION
 INDEPENDENT MEDICAL EXAMINATION PROGRAM
DIVISION IME EXAMINER'S SUMMARY SHEET

1. Claimant Name _____ WC # _____ Date of Injury _____
 2. DIME Physician _____ Appointment Date _____
 3. **Is the claimant at MMI for this injury?** Report Due Date _____
 Yes, the claimant reached MMI on _____ (date) No, the claimant is not at MMI

4. Physician's Rating (Unapportioned Ratings) Whole person impairment

Spine	→	% WP
Extremity Impairment		
	Left upper extremity % UE Convert to WP →	% WP
	Right upper extremity % UE Convert to WP →	% WP
	Left lower extremity % LE Convert to WP →	% WP
	Right lower extremity % LE Convert to WP →	% WP
Psychological	→	% WP
Other	% →	% WP
Final Combined Unapportioned Impairment Rating		% WP

5. To Determine Apportionment, Answer the Following Based On Prior Medical Records or Objective Findings:

No prior injury, no apportionment			Current Rating After Apportionment	
Was the <i>current</i> date of injury before July 1, 2008?	Yes →	A P P O R T I O N	Spine	% WP
↓ No, after July 1,2008 ↓			Left upper extremity % UE	% WP
Was the previous condition work-related ?	Yes →		Right upper extremity % UE	% WP
↓ No, not work-related ↓			Left lower extremity % LE	% WP
Was the previous condition independently disabling?	Yes →		Right lower extremity % LE	% WP
↓ No, not independently disabling ↓			Psychological	% WP
No apportionment can be done.			Other	% WP
↓↓ ↓				
Use Combined Unapportioned rating (from Section 4 above)			Final Combined/Apportioned Rating	% WP

6. Signature _____ Date _____

REMEMBER TO ADDRESS ALL ISSUES ON THE DIME APPLICATION

This form, your narrative report, and applicable worksheets must be completed. Send the original report to the Division with copies to both parties (or their attorneys) within 20 calendar days from the appointment date.

Division of Workers' Compensation – IME Unit
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