Clear Entire Form

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Division IME Physician Summary Disclosure Form (Claimant)

WC#: _____
Name of Claimant: _____
Claimant address: _____
_____

Physician name: _____

Physician address: _____
_____

Instructions:

Pursuant to C.R.S. 8-42-107.2(3.5)(a) and Workers' Compensation Rule of Procedure 11-3, upon request of an interested party a physician on the Division IME panel shall provide to the Division IME Unit a list of business, financial, employment, and/or advisory relationships between a listed physician and the claimant who is a party to the claim. This summary disclosure shall be provided to the Division within 7 business days of the date of the notice of such request.

I. I or my affiliated entities have the following business, financial, employment or advisory relationship with the above-named claimant:

Signed: _____ Dated: _____