COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Notice of Reschedule or Termination of the Division Independent Medical Examination (DIME)

WC#: _____ Claimant Name: _____

☐ The DIME appointment has been **RESCHEDULED** to: _____

☐ The DIME appointment was **TERMINATED**

☐ The **Claimant FAILED TO ATTEND** DIME appointment.

Refer to Rule 11 for associated DIME fees.

CERTIFICATE OF MAILING: Copies of this document were sent to the Division and the following parties this _____ day of _____, _____.

List names and addresses of all persons copied:

Division of Workers' Compensation
DIME Unit
633 17th St., Suite 400
Denver, CO 80202-3626
DIME Unit Email: imeunit@state.co.us | DIME Unit Fax: 303-318-8659

Claimant: _____

Claimant's Attorney: _____

Carrier: _____

Carrier's Attorney: _____

DIME Physician: _____

By: _____
Signature

_____
Print Name

If you have questions about the DIME process, please contact the Division of Workers' Compensation Customer Service at 303-318-8700.

Resource:
https://www.colorado.gov/pacific/cdle/division-independent-medical-exam-dime