COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Notice of Agreement to Limit the Scope of the Division Independent Medical Examination (DIME)

Requesting Party: ☐ Claimant ☐ Carrier

WC#: _____ Claimant Name: _____

Both parties hereby notifying the DIME Physician to **LIMIT THE SCOPE OF THE DIME** on the following issues:

☐ Maximum Medical Improvement

☐ Permanent Impairment

☐ Apportionment

List any specific part(s) of the body and/or conditions NOT TO BE EVALUATED by the DIME Physician:

We hereby certify that the above statements are true and correct to the best of our knowledge.

_____ _____
Requesting Party Signature Date

_____ _____
Non-Requesting Party Signature Date

CERTIFICATE OF MAILING

☐ By checking this box, it is certified that a copy of this document will be attached to the medical record package served to the DIME Physician, next to the dated cover sheet and the chronological index. The parties will also provide a copy of the agreement to the Division IME Unit.