(TYPE OR PRINT)

BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

Form 100A
14-0007 (01/09)

Claimant _____

VS

Employer _____

Street _____

City _____State ____Zip _____

Insurance Carrier _____

Street _____

City _____State ____Zip _____

File Number _____

ORIGINAL NOTICE, PETITION, ANSWER AND ORDER CONCERNING INDEPENDENT MEDICAL EXAMINATION (Iowa Code Section 85.39)

Injury Date _____

Body Part(s) Injured_____

ORIGINAL NOTICE

To the Above-Named Employer:

You are notified that an action has been commenced before the Iowa Workers' Compensation Commissioner seeking relief as set forth in the petition below. You are required to file and serve an answer to the petition **(SEE REVERSE SIDE OF FORM)** within 20 days following your receipt of this document or to otherwise move or respond as provided by Division of Workers' Compensation rules. Failure to comply may result in the imposition of sanctions under rule 876 IAC 4.36 and/or entry of a default and an award for the relief requested. **NOTE:** You should promptly advise your workers' compensation insurance carrier and attorney that you have received this notice.

PETITION (To Be Completed By Claimant)

Claimant requests an independent medical evaluation, at the employer's expense, in accordance with Iowa Code section 85.39, as follows:

Physician Name _____ Examination Date _____

Examination Location (City) _____ State _____

In support of this request claimant states:

1. Claimant sustained injury arising out of and in the course of employment with the employer on (Date) _____.
2. The injury occurred at (City) _____ (County) _____ (State) _____.
3. An evaluation of permanent disability has been made by (Physician Name) _____. as shown on the attached written report, and claimant believes the evaluation is too low.
4. The physician named in paragraph 3 above was retained or paid by the employer and/or insurance carrier.
5. The injury referred to in paragraph 1 was a factor in producing the condition for which the evaluation was made.
6. Evidentiary hearing under Iowa Code section 17A.12 is waived.

I, (Claimant's Signature) _____, Date Signed _____

certify, under penalty of perjury and pursuant to the laws of the State of Iowa, that the preceding petition is true and correct.

Claimant's Phone (Include Area Code)

_____

(If Represented by Attorney)

Attorney _____

Street _____

City _____ State _____ Zip _____

Phone No _____

Fax No. _____

_____

Signature of Attorney

_____

Email Address of Attorney

THE INFORMATION PROVIDED WILL BE OPEN FOR PUBLIC INSPECTION UNDER IOWA CODE §22.11

_____ **VS.** _____ **File No.** _____

Claimant Employer

PROOF OF SERVICE

On the _____ day of _____, _____, I mailed a copy of the foregoing original notice and petition by certified mail, return receipt requested, to the employer's last known address which is: _____

_____

I CERTIFY under penalty of perjury and pursuant to the laws of the State of Iowa that the preceding is true and correct.

Date _____ Signature _____

ANSWER (Employer/Insurance Carrier must answer on this form)

1. Employer/Insurance Carrier admit all allegations of the petition except those contained in paragraphs (Enter numbers) _____ which are expressly denied.
2. Employer/Insurance Carrier consent to pay the reasonable expenses of the requested examination.
3. Evidentiary hearing under Iowa Code section 17A.12 is waived.

On behalf of the employer and insurance carrier and based upon my own knowledge of the circumstances, I certify under penalty of perjury and pursuant to the laws of the State of Iowa that the preceding answer is true and correct. Date: _____

Employer

_____

Street

_____

City _____ State _____ Zip _____

Phone (Include Area Code) _____

Insurer _____

Street _____

City _____ State _____ Zip ____

Phone (Include Area Code) _____

_____

Signature of Person Answering

Name: _____

Title: _____

(If Represented by Attorney)

Attorney _____

Street _____

City _____ State _____ Zip _____

Phone (Include Area Code) _____

Fax Number (include Area Code) _____

Email Address: _____

ORDER (Completed by the deputy workers' compensation commissioner)

☐ Allegations 3 and 4 of the petition are found to be true.

☐ The application is granted. Employer/Insurance Carrier shall immediately reimburse claimant the reasonable expenses of the requested examination, including travel expenses.

☐ The application is denied. Reason: _____

☐ The application will be scheduled for an evidentiary hearing. You will be mailed notice of the time and location of the hearing.

Signed and filed this _____ day of _____, _____

Deputy Workers' Compensation Commissioner _____

Copies To: Attorney(s) at Law or Pro Se _____ Attorney(s) at Law or Pro Se _____

INSTRUCTIONS - BOTH PARTIES MUST USE THIS FORM

To Claimant:

1. You must attach to this form a copy of the physician's report which evaluates your permanent disability to support paragraph "3" of the petition. You must also attach the claimant's confidential information sheet.
2. Deliver a copy of this form with the front page completed and the physician's report to the employer by certified mail, return receipt requested or by personal services as in civil actions (rule 876 IAC 4.7) and mail a copy to the employer's attorney of record for this file if known (rule 876 IAC 4.13).
3. Complete the proof of service portion on the original of this form and deliver this entire form with the physician's report to the Division of Workers' Compensation at 1000 East Grand Avenue, Des Moines, Iowa 50319-0209.
4. If you desire an evidentiary hearing, delete paragraph "6" of the petition and in its place enter "I request a hearing." Rule 876 IAC 4.4.

To Employer/Insurance Carrier:

1 Enter the number of each paragraph of the petition which is denied in the space provided in paragraph “1” of the answer.
2 If you do not consent to the requested examination, delete paragraph “2” of the answer.
3. If you desire an evidentiary hearing, delete paragraph “3” of the answer and in its place enter “I request a hearing.” Rule 876 IAC 4.4.
4. Serve a copy of your answer to the claimant or claimant’s attorney pursuant to rule 876 IAC 4.13.
5 Type or print the name and title of the person answering below the signature line.