Medical Report Transmittal Form

IAC 876-3.1(2)(17A) … Medical data supporting the action taken shall be (provided) when temporary total disability or temporary partial disability exceeds 13 weeks or when the employee sustains a permanent disability. …

Please complete and attach this form to the front of medical data or reports when they are submitted to the Iowa Division of Workers' Compensation.

Jurisdiction Claim Number:	
Claim Administrator Claim Number:	
Claim Administrator Name:	
Employee ID (number):	
Date of Injury:	
Employee Last Name:	
Employee First Name:	
Current Return to Work Date: (if applicable)	
Date of Maximum Medical Improvement: (if applicable)	
Permanent Impairment Body Part Code: (if applicable)	
Permanent Impairment Percentage: (if applicable)	
Doctor's Name:	
Comments:	

Please Mail or Fax to:

Division of Workers' Compensation
1000 East Grand Avenue
Des Moines, Iowa 50319-0209
Fax Number: (515) 281-6501

IOWA WORKFORCE DEVELOPMENT

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