BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

_____, Claimant, vs. _____, Employer, _____, Insurance Carrier, _____, Defendant(s).	File No(s).: _____ _____ **Answer Concerning Independent Medical Examination**

1. Employer's name is: _____
2. Employer's address is: _____
3. Insurance carrier's name is: _____
4. Insurance carrier's address is: _____
5. Employer/insurance carrier admit the allegations in the following paragraph(s) of the Petition:

   _____

6. Employer/insurance carrier deny the allegations in the following paragraphs(s) of the Petition:

   _____

7. Employer/insurance carrier:

   ☐ Consent to pay the reasonable expenses of the requested examination.

   ☐ Do not consent to pay the expenses of the requested examination because:

8. Employer/insurance carrier:

   ☐ Waive an evidentiary hearing under Iowa Code section 17A.12.

   ☐ Request an evidentiary hearing.

-or-

Signature of Attorney for Defendant(s)

Name (PIN): _____

Email: _____

Phone: _____

Fax: _____

Address: _____

Signature of Representative of Employer

Name, Title: _____

Email: _____

Phone: _____

Fax: _____

Address: _____

Certificate of Service

I, _____, hereby certify that a copy of this document was served upon counsel of record for each party or each unrepresented party to this case on _____, by:

☐ Iowa Workers' Compensation Electronic System (WCES)

☐ Other: _____

_____ _____

Signature Date