BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

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

ORIGINAL NOTICE TO EMPLOYER

- The claimant has filed a Petition Concerning Independent Medical Examination with the Iowa Workers' Compensation Commissioner, seeking relief under Iowa Code section 85.39 as set forth in the Petition below.
- You must file and serve an answer within 20 days of your receipt of this document or otherwise respond under 876 IAC Chapter 4. Failure to comply may result in entry of default against you and an award of the relief requested and/or sanctions under Rule 876 IAC 4.36.
- You should promptly advise your workers' compensation insurance carrier and attorney that you received this notice.

PETITION

1. Employer's last-known address is: _____
2. Insurance carrier's address is: _____
3. Claimant sustained injury arising out of and in the course of employment with the employer on the date(s) of:

   _____
4. Claimant's injury occurred in the following city, county, and state:

   City: _____ County: _____ State: _____
5. Body part(s) affected or disabled: _____
6. An evaluation of permanent disability was made by the following physician:

   _____
7. The physician named in Paragraph 6 was retained or paid by the employer and/or insurance carrier.

8. The injury described in Paragraphs 3 through 5 was a factor in producing the condition for which the physician named in Paragraph 6 performed the evaluation of permanent disability.

9. Claimant believes the evaluation contained in the attached report by the physician named in Paragraph 6 is too low.

10. Claimant requests an independent medical examination, at the employer's expense, under Iowa Code section 85.39, as follows:

    Physician Name: _____

    Examination Date: _____

    City and State of Examination: _____

11. Claimant:

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

    ☐ Requests an evidentiary hearing.

-or-

Signature of Attorney for Claimant		Signature of Self-Represented Claimant	
Name (PIN):		Name:	
Email:		Email:	
Phone:		Phone:	
Fax:		Fax:	
Address:		Address:	

Proof of Service

I, _____, hereby swear or affirm under Iowa law and the penalty of perjury that on _____ I served a copy of the foregoing instrument by:

☐ Certified mail, return receipt requested, to the employer's address provided in Paragraph 1 of the Petition.

☐ Other: _____.

_____ _____

Signature Date