

REQUEST FOR INDEPENDENT MEDICAL EXAMINER



Requester Name, Address, and Telephone:

Nebraska Workers' Compensation Court

State Capitol Building

P.O. Box 98908

Lincoln, NE 68509-8908

800-599-5155

402-471-6460

Attach a separate sheet of paper to add additional information.

Employee Name, Social Security #, Address, and Telephone:

Representing:

Employer Name, Address, and Telephone:

Date of Injury:

Description of Injury:

Identify All Attorneys Currently Representing Any Party by Name, Address, Telephone, and Client Name:

Insurer Name, Address, and Telephone:

Name, Address, and *Specialty* of all physicians who have treated or examined the employee for this injury:

Define the disputed medical issues which require the opinion of an Independent Medical Examiner.

List the specific questions related to the disputed medical issues that you wish to be submitted to the examiner.

Preferred specialty, if any, of independent medical examiner. The court is not bound by such preference.

Requester must send the original form to the Nebraska Workers' Compensation Court and copies of the form to the employee, the employer, the insurer, and all attorneys.