

NOTICE OF AGREEMENT

TO USE A NAMED INDEPENDENT MEDICAL EXAMINER



Initiator: Name, Address, and Telephone

Nebraska Workers' Compensation Court

State Capitol Building

P.O. Box 98908

Nebraska only (800) 599-5155

Lincoln, NE 68509-8908

(402) 471-6459

Attach a separate sheet of paper to add additional information.

Representing:

The parties have agreed to use the physician named below to perform an independent medical examination.

Employer/Insurer/Representative Signature

Employee/Representative Signature

Employer: Name, Address, Telephone, and Attorney's Name (if represented in this case)

Employee: Name, Social Security #, Address, Telephone, and Attorney's Name (if represented in this case)

Insurer: Name, Address, Telephone, and Attorney's Name (if represented in this case)

Date of Injury:

Description of Injury:

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

Name of Agreed Upon Independent Medical Examiner: _____

Signature required if the physician is not on the list of court-appointed independent medical examiners

I acknowledge that I am not on the list of court-appointed independent medical examiners. However, I agree to perform an independent medical examination for the above employee in accordance with the Nebraska Workers' Compensation Act and the Court's Rules of Procedure (63-65).

Physician Signature: _____

Date: _____

Questions submitted to the independent medical examiner:

Initiator 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.