

NOTICE OF AGREEMENT TO USE A NAMED INDEPENDENT MEDICAL EXAMINER



Initiator: Name, Address, and Telephone

Nebraska Workers' Compensation Court
P.O. Box 98908
Lincoln, NE 68509-8908

800-599-5155
402-471-6468

Attach a separate sheet of paper to add additional information.

Representing:

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

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

Employer/Insurer/Representative Signature

Employee/Representative Signature

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:

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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:

Submit with certificate of service as proof that all other parties have been served a copy of the request.