BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

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

1. Employer's name: _____
2. Employer's address: _____
3. Insurance carrier's name: _____
4. Insurance carrier's address: _____
5. Employer/insurance carrier admit the allegations contained in the following paragraphs of the petition:

   _____
6. Employer/insurance carrier deny the allegations contained in the following paragraphs 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 for the following reason(s):

8. Employer/insurance carrier:
   - ☐ Waive an evidentiary hearing under Iowa Code section 17A.12.
   - ☐ Request an evidentiary hearing.

Signature of Attorney for Defendant(s) – *or* – Representative of Defendant(s)

Full Name: _____

Law Firm/Entity: _____

Telephone: _____

Email: _____

Mailing Address: _____

_____

_____

CERTIFICATE OF SERVICE

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

☐ Iowa Workers' Compensation Electronic System (WCES).

☐ Other: _____

Signature

Date