BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

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

TO THE ABOVE-NAMED DEFENDANT(S):

- You are notified that the above-named claimant filed with the Iowa Division of Workers' Compensation (DWC) this original notice and petition naming you as the defendant(s).
- You must file with DWC an answer or otherwise respond within 20 days of receipt of this document. If you do not, the DWC may enter judgment by default against you for the relief demanded in the petition or impose sanctions under Iowa Administrative Code rule 876—4.36.
- You are advised to seek legal advice at once to protect your interests. If applicable, you should promptly notify your workers' compensation insurance carrier.

PETITION

1. Employer's address: ____________________
2. Insurance carrier's address : ____________________
3. Claimant sustained injury arising out of and in the course of employment with the employer on: ____________________
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 by the physician named in Paragraph 6 is too low.
10. The report containing the evaluation described above is: ☐ Attached. ☐ Not attached.

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

a. Physician Name: ______________________

b. Date of Examination: ______________________

c. City and State of Examination: ______________________

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

☐ Requests an evidentiary hearing.

Claimant prays the agency award the relief sought under Iowa Code section 85.39 by ordering reimbursement to the claimant of the reasonable fee for the independent medical examination described in Paragraph 10 and all reasonably necessary transportation expenses incurred for the examination.

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Signature of Claimant's Attorney – *or* – Self-Represented Claimant

Full Name: ______________________

Law Firm: ______________________

Telephone: ______________________

Email: ______________________

Mailing Address: ______________________

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PROOF OF SERVICE

I, ______________________, hereby swear or affirm under Iowa law and the penalty of perjury that, in accordance with Iowa Code section 85.39(2), on the date of ______________________, I served a copy of the foregoing instrument:

☐ By certified mail, returned receipt requested, on the employer at the address provided in Paragraph 1.

☐ Other: ______________________

______________________ ______________________

Signature Date