RETURN TO:
OFFICE OF WORKERS' COMPENSATION
POST OFFICE BOX 94040
BATON ROUGE, LA 70804-9040
(225) 342-7559
TOLL FREE (800) 201-2494

1. Social Security No. _____-_____-_____
2. Date of Injury/Illness _____-_____-_____
3. Part(s) of Body Injured _____
4. Date of Birth _____-_____-_____
5. OWC Docket Number _____
6. OWC District Number _____

REQUEST FOR INDEPENDENT MEDICAL EXAMINATION

NOTE: THIS REQUEST WILL NOT BE HONORED
UNLESS A DISPUTE HAS ARISEN AS TO
CONDITION OF THE EMPLOYEE AS PER L.R.S. 23:1123.

7. This form is submitted by:
☐ Employee ☐ Employer ☐ Insurer ☐ TPA/Self Insurance Fund

A. The choice of the medical practitioner shall be that of the Director of the Office of Workers' Compensation as per L.R.S. 23:1123.
B. A cover letter outlining the conflicting medical issue(s) in dispute (reason for request) along with the conflicting medical reports must be attached to this form.
C. A list of names, addresses, phone numbers and reports of all physicians/medical providers who have treated or examined the injured employee for this injury must be included. Indicate who chose each health care provider.
D. A copy of this request must be mailed to all parties.

EMPLOYEE

8. Name _____
Street or Box _____
City _____
State _____ Zip _____
Phone ( ) _____

EMPLOYEE'S ATTORNEY

9. Name _____
Street or Box _____
City _____
State _____ Zip _____
Phone ( ) _____

EMPLOYER

10. Name _____
Street or Box _____
City _____
State _____ Zip _____
Phone ( ) _____

INSURER / ADMINISTRATOR
(circle one)

11. Name _____
Street or Box _____
City _____
State _____ Zip _____
Phone ( ) _____

EMPLOYER / INSURER'S ATTORNEY
(circle one)

12. Name _____
Street or Box _____
City _____
State _____ Zip _____
Phone ( ) _____

_____
Signature of Applicant **Date**

LDOL-WC 1015
REVISED 1/98