

## Tennessee Bureau of Workers' Compensation 220 French Landing Drive, I-B Nashville, TN 37243-1002 800-332-2667

## REQUEST TO MIR PROGRAM FOR A MEDICAL IMPAIRMENT RATING

Requesting Party:	Employee	Employee	e Atty.	Empl	oyer/Carrier	Employer/Carrier Atty.
State File #		Date of Injury		Date of MMI		[
Please list all affected b	oody part(s)	) or organ syste	m(s) for whi	ch the	medical impairm	ent rating is disputed:
Body Part/Organ System		Side	Joint			Part of Spine
(i.e. finger, eye, jaw, lungs, h	neart, spine)	(left or right?)	(hip, shoulder	, wrist,	elbow, knee, hip, ankl	e) (upper, middle, lower)
Employee Name					SSN:	
DOB	Pho	ne		Emai	il	
Home Address						
Employee's Attorney				E	-Mail	
Practice Name						
Address 2					Fax	
Is an interpreter needed	for the eva	aluation? No	Yes		s, primary language spoker	
Is a Bureau of Workers	' Compens	ation Specialist	currently as	signed	to the case? No	Yes
If yes, name of the Spec	cialist					
Has mediation with the	Bureau be	en requested? N	No Yes		_ If yes, scheduled d	ate
Is the Second Injury Fu	nd involve	d? No Yes	1	f yes,	atty. name	
Employer Name						

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Address		
City	State ZIP	
Employer's Attorney	E-Mail	
Practice Name		
Business Address		Phone
Address 2		_ Fax
City	State ZIP	
Insurance Carrier		
Adjuster Name	Email	
Business Address		Phone
City	State ZIP	

Please list all physicians who have issued an impairment rating in this matter, indicating the body part(s) or organ system(s) evaluated, the work-related diagnosis given, and the rating issued. For back injuries, please specify whether the upper back (cervical), lower back (lumbar), or mid-back (thoracic) was rated. For extremities, please specify which joint or part (hand, thumb, wrist, elbow shoulder, hip, knee, ankle, foot, toe) and side (left or right) was rated.

PHYSICIAN NAME, PRACTIC NAME, ADDRESS (Please include Street, City, State, and Zip)	BODY PART/ORGAN SYSTEM EVALUATED	EXACT WORK-RELATED DIAGNOSIS	IMPAIRMENT RATING
(1)			
(2)			
(3)			
(4)			
(5)			
(6)			

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## Please provide the names of all treating physicians in this case.

Printed name		 nature	 Date
help resolve the disput Form, a copy of the F	te related to the above-detaile	d injury. If appropriate, I a an Panel and a copy of the	de a list of MIR Physicians to m including, with this Request e permanent restrictions if this
Employee	Employee's Attorney	Employer's Attorney	Insurance Carrier
document were place	ed in the U.S. Mail or del 20 Circle all persons cop	ivered to the following	
The requesting party s		ate of Mailing	d to the Program. Copies of this
(1)		(14)	
(7)		(14)	
(0)		(13)	
(6)		(13)	
(5)		(12)	
(F)		(12)	
(4)		(11)	
(4)		(11)	
(3)		(10)	
(2)		(4.0)	
(2)		(9)	
(1)		(8)	
PHYSICIAN NAME, PRA (Please include Street, City	ACTIC NAME, ADDRESS y, State, and Zip)		

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