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

NOTICE OF DEMAND FOR EXAMINATION

This form is to be used when an employee has been determined, by trial or settlement, to be permanently and totally disabled and the employer, insurer, or the Bureau of Workers' Compensation when the Subsequent Injury Fund is involved wants to seek reconsideration of the issue of permanent total disability. This form shall not be used unless:

- **At least 24 months have elapsed since the entry of the final order which determined permanent total disability was appropriate, and/or 24 months have lapsed since the last request for examination, and**
- **The requesting entity has first made informal contact with the employee named below, either by letter or telephone, to attempt to schedule an appointment with a physician for an examination at a mutually agreeable time and place, and those efforts have failed.**

This request is subject to considerations of reasonableness by an appropriate Court.

To make this demand, this fully completed form must be sent to the employee by certified mail, return receipt requested, by the requesting entity. The cost of this examination shall be paid by the requesting entity.

State File Number _____ Date of this Notice _____

Employee Name_____

Mailing Address _____

City_____ State_____ Zip_____

Phone #_____ Email address _____

The details of the examination are indicated below:

Physician Name _____

Group/Practice d/b/a _____

Office Street Address _____

City_____ State_____Zip_____

Phone #_____Date and time of examination _____

The employee is required to either:

- **Submit to the examination as scheduled above, or**
- **Schedule an appointment with the same physician named above within 30 days from the date of this notice. That appointment must be completed within 90 days from the date of the notice.**

The employee's periodic benefits shall be suspended for a period of 30 days if the employee fails to comply with either of these two requirements.

Requesting Entity _____

Business Mailing Address _____

City, State, ZIP _____

Employer_____

Employer Mailing Address _____

City, State, ZIP _____

Insurer _____

Insurer Mailing Address _____

City, State, ZIP _____

Signature of requesting entity representative _____

Printed name of requesting entity representative_____

Requesting entity email _____ Phone # _____