



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 Atty. Employer/Carrier Employer/Carrier Atty.

State File # _____ Date of Injury _____ Date of MMI _____

Please list all affected body part(s) or organ system(s) for which the **employer and employee agree** causation is **accepted** and **ONLY** the medical impairment rating is disputed:

Body Part/Organ System (i.e. finger, eye, jaw, lungs, heart, spine)	Side (left or right?)	Joint (hip, shoulder, wrist, elbow, knee, hip, ankle)	Part of Spine (upper, middle, lower)

Employee Name _____ **SSN:** _____

DOB _____ **Phone** _____ **Email** _____

Home Address _____

City _____ **State** _____ **ZIP** _____

Employee's Attorney _____ **E-Mail** _____

Practice Name _____

Business Address _____ **Phone** _____

Address 2 _____ **Fax** _____

City _____ **State** _____ **ZIP** _____

Is an interpreter needed for the evaluation? No Yes

If yes, primary language spoken

Is a Bureau of Workers' Compensation Specialist currently assigned to the case? No Yes

If yes, name of the Specialist _____

Has mediation with the Bureau been requested? No Yes If yes, scheduled date _____

Is the Second Injury Fund involved? No Yes If yes, atty. name _____

Employer Name _____

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 _____

Address 2 _____ Fax _____

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)			

