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 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)			

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

PHYSICIAN NAME, PRACTIC NAME, ADDRESS (Please include Street, City, State, and Zip)	
(1)	(8)
(2)	(9)
(3)	(10)
(4)	(11)
(5)	(12)
(6)	(13)
(7)	(14)

Certificate of Mailing

The requesting party shall send a copy of this application to the other party and to the Program. Copies of this document were placed in the U.S. Mail or delivered to the following parties this _____day of _____, 20____. Circle all persons copied:

Employee **Employee's Attorney** **Employer's Attorney** **Insurance Carrier**

I hereby request the Tennessee Bureau of Workers' Compensation to provide a list of MIR Physicians to help resolve the dispute related to the above-detailed injury. If appropriate, I am including, with this Request Form, a copy of the Form C-42 Choice of Physician Panel and a copy of the permanent restrictions if this request is due to 0% Impairment Rating that included permanent restrictions.

_____ _____ _____

Printed name **Signature** **Date**