Reset Form

EMPLOYEE WAIVER OF EXAMINATION BY PERSONAL PHYSICIAN

State Form 53913 (4-09)

INDIANA WORKER'S COMPENSATION BOARD
402 West Washington Street, Room W196
Indianapolis, IN 46204

INSTRUCTIONS: Please have claimant complete this form.
Submit together with Agreement to Compensation (Form 1043).

I have read the report of Dr. _____, dated the ____ day of _____, 20___, and understand that this medical opinion states that I have a _____% permanent partial impairment of the _____ as a result of injuries sustained in the above mentioned accident.

I, _____, understand that, pursuant to the Workers Compensation Act of Indiana, I have the right to have an examination by a qualified physician of my choice, at my own expense, for the purpose of determining what degree of permanent partial impairment, if any, I may have as a result of injuries suffered on the _____ day of _____, 20____, while in the employ of _____. I understand that any impairment rating obtained from such an examination is not binding upon the employer or insurance carrier, although it may be taken into consideration.

I do not wish to have an examination by a physician of my own choice and I hereby accept and agree with the opinion of Dr. _____ concerning the extent of my permanent injuries as described in the attached report. I understand that this waives only my right to an examination by a physician of my own choosing regarding this particular settlement.

Signed and dated this _____ day of _____, 20____.

X_____
Signature of Employee