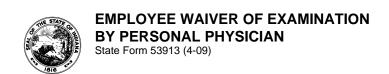
INDIANA WORKER'S COMPENSATION BOARD 402 West Washington Street, Room W196 Indianapolis, IN 46204



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

I have read the report of Dr.	, da	ated the	day of	,
20, and understand that this medical opinion sta	tes that I have a	% p	ermanent partial impairme	nt of
the as a result of	injuries sustained in	the above	mentioned accident.	
I,, und	erstand that, pursuan	t to the W	Vorkers Compensation Ac	ct of
Indiana, I have the right to have an examination by	a qualified physician	of my choi	ce, at my own expense, fo	r the
purpose of determining what degree of permanent	partial impairment,	if any, I m	ay have as a result of inju	uries
suffered on the day of, 20_	, while in the em	ploy of		
I understand that any impairment rating obtained f	rom such an examina	tion is not	binding upon the employe	er or
insurance carrier, although it may be taken into co	nsideration.			
I do not wish to have an examination by a p	hysician of my own c	hoice and	I hereby accept and agree	with
the opinion of Dr.	_ concerning the exter	nt of my per	rmanent injuries as describ	ed in
the attached report. I understand that this waives	only my right to an	examinati	on by a physician of my	own
choosing regarding this particular settlement.				
Signed and dated this day of	, 20			
	X			
	Signature of Emplo	yee		