REQUEST FOR DESIGNATION OF A PHYSICIAN TO PERFORM AN IMPAIRMENT RATING EVALUATION

Sample form for informational purposes only. Not valid for filing. Electronic filing in WCAIS is the only prescribed filing format.

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY

WCAIS CLAIM NUMBER

DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS’ COMPENSATION

SEE IMPORTANT INFORMATION ON THE REVERSE
Description of compensable injury:


This is an Act 46 (firefighter cancer) claim ☐

The referenced Insurer/Employer requests the Bureau of Workers’ Compensation to select a physician for an Impairment Evaluation to be conducted with Section 306(a.3) of the Workers’ Compensation Act.

Copies of this request have been served on all parties.

Claims Representative’s signature

Claims Representative’s name (typed/printed)

Telephone

Mail to:
1171 S. Cameron Street, Harrisburg, PA 17104

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers’ Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).