



STATE OF TENNESSEE
DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

Workers' Compensation Division
Medical Impairment Rating Program
Andrew Johnson Tower
710 James Robertson Parkway, 2nd Floor
Nashville, TN 37243-0661
Phone (615) 253-1613 Fax (615) 253-5263

Application for a Medical Impairment Rating (MIR)

Requesting Party (check one) _____ **Employee** _____ **Employer** _____ **Insurance Carrier**

Name of person requesting MIR _____

Contact Information: Phone # _____ **E-mail** _____

Relationship to the Requesting party _____
(Attorney, Union Representative, Family member, etc.)

State File # _____ **Date of Injury** _____

Employee Name _____ **SSN #** _____

Home Address _____ **Date of Birth** _____

City _____ **State** _____ **Zip** _____ **Phone #** _____

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

Business Address _____ **Phone #** _____

Address 2 _____ **Fax #** _____

City _____ **State** _____ **Zip** _____

Employer Name _____ **FEIN #** _____

Contact Name _____ **Title** _____

Business Address _____ **Phone #** _____

Address 2 _____ **Fax #** _____

City _____ **State** _____ **Zip** _____

Employer's Attorney _____ E-Mail _____

Business Address _____ Phone # _____

Address 2 _____ Fax # _____

City _____ State _____ Zip _____

Insurance Carrier _____ E-Mail _____

Adjuster Name _____ Title _____

Business Address _____ Phone # _____

Address 2 _____ Fax # _____

City _____ State _____ Zip _____

Please designate the specific body part(s) and all conditions to be evaluated.

<input type="checkbox"/> Upper Extremities (Arms, Hands and/or Fingers including shoulders, elbows and wrists)	<input type="checkbox"/> Lower Extremities (Legs, Feet and/or Toes including hips, knees and ankles)	<input type="checkbox"/> Skin (Including Scars, Skin grafts, Dermatitis, Rubber latex allergies, and Skin cancer)
<input type="checkbox"/> Neck or Back	<input type="checkbox"/> The spine and spinal cord	<input type="checkbox"/> Mental or Behavioral Disorders (Including psychiatric impairment)
<input type="checkbox"/> Central and Peripheral Nervous System (Including injuries to the Brain, Gait and movement disorders, Chronic pain, and Neuromuscular injuries)	<input type="checkbox"/> Heart or Cardiovascular System (Including Heart diseases Arrhythmias, and Cardiomyopathies)	<input type="checkbox"/> Lungs or Respiratory System (Including Asthma, Sleep apnea, Pneumoconiosis, and Lung cancer)
<input type="checkbox"/> Ear, Nose, and Throat and related structures (Including Facial disfigurement, Hearing loss, Voice and/or Speech impairment, and Chewing and/or swallowing impairment)	<input type="checkbox"/> Bone Marrow, Lymph nodes, Spleen, White blood cell diseases, and Blood-circulating cells	<input type="checkbox"/> Digestive System (Including the Colon, Liver and/or Hernias)
<input type="checkbox"/> Eyes and the Visual System	<input type="checkbox"/> Urinary and Reproductive Systems (Including the Bladder and/or Urethra)	<input type="checkbox"/> Endocrine System (Including the Thyroid, Gonads and/or Pancreas)
<input type="checkbox"/> Female Breast		

Is a Workers' Comp Specialist currently assigned to the case? _____ NO _____ YES

If so, name of Specialist _____

Has a Benefit Review Conference been requested? _____ NO _____ YES _____
If so, scheduled date

Is an interpreter needed for the evaluation? _____ NO _____ YES _____
If so, primary language spoken

Medical Treatment Information

Names of all physicians who have issued an impairment rating in this matter and the rating issued.

Names of physicians made available to the injured worker. Use additional form if necessary.

Physician Name _____ Phone # _____

Office Address _____
Street City State Zip

Physician Name _____ Phone # _____

Office Address _____
Street City State Zip

Physician Name _____ Phone # _____

Office Address _____
Street City State Zip

Physician Name _____ Phone # _____

Office Address _____
Street City State Zip

Physician Name _____ Phone # _____

Office Address _____
Street City State Zip

Physician Name _____ Phone # _____

Office Address _____
Street City State Zip

Names of all employer-paid treating physicians in this case

Physician Name _____ Phone # _____

Office Address _____
Street City State Zip

Physician Name _____ Phone # _____

Office Address _____
Street City State Zip

Physician Name _____ Phone # _____

Office Address _____
Street City State Zip

Physician Name _____ Phone # _____

Office Address _____
Street City State Zip

Physician Name _____ Phone # _____

Office Address _____
Street City State Zip

Names of all employee-paid treating physicians in this case

Physician Name _____ Phone # _____

Office Address _____
Street City State Zip

Physician Name _____ Phone # _____

Office Address _____
Street City State Zip

Physician Name _____ Phone # _____

Office Address _____
Street City State Zip

Certificate of Mailing

The requesting party shall send a copy of this application to the other party and to the Program Coordinator. 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

By: _____
Signature Date

Informational Summary

The following is a brief outline of the Workers' Compensation Medical Impairment Rating process.

1. To obtain the legal presumption of accuracy for the resulting impairment rating report afforded in Section 50-6-204(d)(5) of the Act, the parties must select the physician to conduct the evaluation pursuant to the procedures stated in the rules governing the MIR program.
2. Either party may request an impairment evaluation. The requesting party is responsible for completing this form. Within five (5) calendar days of receiving this application, the Program Coordinator will produce the listing requested and will provide those names to the parties.
3. If the parties are unable to mutually agree on a selection from the initial listing provided, either party may request a three-physician assignment from the Registry.
4. After a three-physician assignment has been supplied, the employer will have three (3) business days to strike one name from the listing and to notify the employee and the Program Coordinator. The employee then has three (3) business days to strike another name and to notify the Program Coordinator and the employer of the remaining name. If one party fails to timely strike a name, the other party should promptly notify the Program Coordinator of the name that it wishes to strike and to request assistance. Time extensions will be granted only for good cause shown.
5. The Program Coordinator will notify the selected physician and will schedule the appointment.
6. If necessary, the claimant shall promptly sign a release form permitting the release of all pertinent medical records. Both parties must submit all pertinent medical records to the chosen physician and the other party at least ten (10) calendar days prior to the evaluation. Supplemental medical records must be submitted at least five (5) calendar days prior to the evaluation or as otherwise arranged by the Program Coordinator. In cases involving incomplete medical record submission, the other party should notify the Program Coordinator for assistance.
7. The employer is responsible for paying for the evaluation.
8. The physician shall submit the MIR evaluation report to the Program Coordinator, only.
9. If the parties want to cancel the evaluation, they should contact the MIR Program Coordinator.