

# REPORT OF CLAIM STATUS REQUEST FOR INDEPENDENT MEDICAL EXAMINATION State Form 38911 (Ref / 5-87)

PRIVACY NOTICE

"This agency is requesting disclosure of your Social Security number in accordance with IC 22:3-4-13. This disclosure is not mandatory and you will not be penalized for refusing.

Acci dent num ber

INSTRUCTIONS- Complete appropriate sections of this document and sign in the space below

Name of insurer claim number Date of injury			CLAIM	INFORMATION		
Date of injury  Address (oby, state, ZIP code)    Telephone number   Code of injury	Name of employer		Federal I.D. Number			
Telephone number address of employee    Social Security Number   Address of employee	Name of insurer			Insurer claim number		
DENETRY REMINATION   DENIAL NOTICE (check appropriate action)	Address (city, state, ZIP code)					
Notice of denial must be made writing and mailed not later than twenty nine. (29) days after the employer's knowledge of the injury (10: 22-3-7). Peper ocorpensation payments the appropriate section below, if applicable.  Refusal to work.  Claim deemed not compensable.  Benefit termination (see compensable payments section below).  Refusal to accept medical resemble period of refusal (10: 22-3-3-4).  Refusal to accept employer shall result in a suspension of all compensation otherwise payable during the period of refusal (10: 22-3-3-4).  Refusal to accept employment suitable to your partial disability shall bar any compensation during such refusal unless, in the opinion of the Worker's Compensation Board of indicana, such refusal was justified (10: 22-3-3-11).  Other (specify)  If the employer disagrees with the proposed termination, the employer must give a written notice to the Worker's Compensation Board and employer within several (7) days after receipt of this termination notice (10: 22-3-3-7). See Independent Medical Board and employer within several (7) days after receipt of the below prescribed form (10: 22-3-3-7).  **Refusal to accept a section below.**  **COMPENSATION PAYMENTS**  All compensation payments should be reported to the Board on the below prescribed form (10: 22-3-3-7).  **Employers who disagree with proposed benefit termination must serve a copy of this disagreement notice to the Worker's Compens Board and the employer within (7) days after receipt of the termination portion of this notice. Please sign below to me an independence medical examination reported and service of the proposed termination.  **Employer disagrees with proposed termination:**  **Employer and employer must sign below	same of empli	cyme	*Social Security Number			
Notice of denial must be made writing and mailed not later than twenty nine. (29) days after the employer's knowledge of the injury (10 22-3-7). Report compensation payments the appropriate section below, if applicable.  Refusal to work  Claim deemed not compensable  Benefit termination (see compensable)  Refusal to accept medical treatment, services and supplies, provided by or on behalf of your employer, shall bar your compensation otherwise payable during the period of refusal (10 22-3-3-4).  Refusal to allow an autopy shall result in a suspension of all compensation (IC 22-3-3-4).  Refusal to allow an autopy shall result in a suspension of all compensation (IC 22-3-3-1).  Other (specify)  If the employere disagrees with the proposed termination, the employer must give a written notice to the Worker's Compensation Board of inclainal, such refusal values possible (IC 22-3-3-1). See Independent Medical Examination Prequest section below.  All compensation payments should be reported to the Board on the behave prescribed form (IC 22-3-3-7).  Employers who disagree with proposed benefit termination must serve a copy of this disagreement notice to the Worker's Compensation Board and the employer within (27) days after receipt of the termination payments and independent medical examination resolves a manufactor to provide an independent employer within (27) days after receipt of the termination on the following payments are provided by the proposed termination must serve a copy of this disagreement notice to the Worker's Compensation Board and the employer within (27) days after receipt of the termination on the provided of payments an independent medical examination in provide a manufactor in provide a medical examination.  Employer and employee must sign below to certify service or admonsted provided to employee.  Employer and employee must sign below to certify service or admonsted provided from the proposed from the propo						
Refusal to accept employer station payments section below:  Refusal to accept employer station Board of Indiana, such refusal was justified (E. 22-3-3-1).  Refusal to accept employer station Board of Indiana, such refusal was justified (E. 22-3-3-1).  Refusal to allow an autopsy shall result in a suspension of all compensation (IC 22-3-3-6).  Refusal to accept employment suitable to your partial disability shall bar any compensation during such refusal unless, in the opinion of the Worker's Compensation Board of Indiana, such refusal was justified (IC 22-3-3-11).  Other (specify)  If the employer disagrees with the proposed termination, the employee must give a written notice to the Worker's Compensation Board and employer within sever (17 days after recept of this termination notice (IC 22-3-3-7). See Independent Medical Examination Requests section below.  **COMMENSION PAYMENTS**  All compensation payments should be reported to the Board on the below prescribed form (IC 22-3-3-7).  **weeks paid**  Ped to (name)  **Imployee**  **Dependent**  **Dependent*		denial must be made w	riting and mailed not later ti	han twenty nine (29)	days after the emplo	yer's knowledge of the injury
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**M Carnoy** 

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#### **Table of Contents Idaho Workman Compensation Report Forms**

- 1. Understanding the eBook Idaho Workman Compensation Report Forms
  - The Rise of Digital Reading Idaho Workman Compensation Report Forms
  - Advantages of eBooks Over Traditional Books
- 2. Identifying Idaho Workman Compensation Report Forms
  - Exploring Different Genres
  - Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
- 3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Idaho Workman Compensation Report Forms
  - User-Friendly Interface
- 4. Exploring eBook Recommendations from Idaho Workman Compensation Report Forms
  - Personalized Recommendations
  - $\circ\,$  Idaho Workman Compensation Report Forms User Reviews and Ratings
  - Idaho Workman Compensation Report Forms and Bestseller Lists
- 5. Accessing Idaho Workman Compensation Report Forms Free and Paid eBooks
  - Idaho Workman Compensation Report Forms Public Domain eBooks
  - Idaho Workman Compensation Report Forms eBook Subscription Services
  - Idaho Workman Compensation Report Forms Budget-Friendly Options

- 6. Navigating Idaho Workman Compensation Report Forms eBook Formats
  - o ePub, PDF, MOBI, and More
  - Idaho Workman Compensation Report Forms Compatibility with Devices
  - Idaho Workman Compensation Report Forms Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of Idaho Workman Compensation Report Forms
  - Highlighting and Note-Taking Idaho Workman Compensation Report Forms
  - Interactive Elements Idaho Workman Compensation Report Forms
- 8. Staying Engaged with Idaho Workman Compensation Report Forms
  - Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Idaho Workman Compensation Report Forms
- 9. Balancing eBooks and Physical Books Idaho Workman Compensation Report Forms
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Idaho Workman Compensation Report Forms
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Idaho Workman Compensation Report Forms
  - Setting Reading Goals Idaho Workman Compensation Report Forms
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Idaho Workman Compensation Report Forms
  - Fact-Checking eBook Content of Idaho Workman Compensation Report Forms
  - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
- 14. Embracing eBook Trends
  - Integration of Multimedia Elements

• Interactive and Gamified eBooks

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