State of Nevada
Department of Business and Industry
DIVISION OF INDUSTRIAL RELATIONS
Workers' Compensation Section

400 West King Street, Suite 400
Carson City, Nevada 89703
(775) 684-7270 (775) 687-6305 FAX

1301 North Green Valley Pkwy., Suite 200
Henderson, Nevada 89074
(702) 486-9080 (702) 990-0363 FAX

REQUEST FOR A ROTATING RATING PHYSICIAN OR CHIROPRACTOR

Name of Requestor: _____ Date: _____

Address: _____ Phone: _____ FAX: _____

City: _____ State: _____ Zip: _____

Requestor is: _____ Insurer/Third-Party Administrator; _____Injured Employee;

_____*Injured Employee's Attorney or Representative; _____Other (Specify)

**Please provide a signed release or power of attorney*

Insurer/Third-Party Administrator/

Association of Self-Insured Employers Name: _____ Certificate #: _____

Self-Insured Employer's Name: _____ Certificate #: _____

Employer Name: _____

Injured Employee's Name: _____

Injured Employee's Address: _____

City: _____State: _____ Zip: _____

Social Security Number: ____-____-____ Claim Number: _____ Date of Injury: _____

INSURER'S INITIAL REQUEST

Stable & Ratable Received: _____Name(s) of Treating & Evaluating Doctor(s): _____

Body Part(s) Codes: _____ _____ _____

Body Part(s) to be evaluated _____ _____ _____

Diagnosis: _____

Name(s) of Doctor(s) who reviewed for possible PPD _____

If a specific specialty is ordered by a hearing or appeals officer, the decision must be attached

FOR ADDITIONAL RATING PHYSICIAN/CHIROPRACTOR REQUESTS ONLY

Date(s) of prior PPD Evaluation(s): _____ Prior Rating Doctor(s): _____

Name of Treating Physician(s)/Chiropractor(s): _____

Body Part(s) Codes: _____ _____ _____

Body Part(s) to be evaluated: _____ _____ _____

Diagnosis: _____

Reason for additional request: _____

If a specific specialty is ordered by a hearing or appeals officer, the decision must be attached

INSURER AND INJURED EMPLOYEE ASSIGNMENT/AGREEMENT OF RATER

Assigned or Agreed by: _____ Date of Assignment/Agreement: _____

Physician/Chiropractor Assigned or Mutually Agreed to: _____

Assigned Rating Physician/Chiropractor's Phone Number: _____

*****Notice to requestor: Hard copy will not follow by mail.***

Compliance with NAC 616C.103(3)c(1)(2)(3)(4)(5) is required