

Request For A Rotating Physician Or Chiropractic Physician

State of Nevada - Department of Business and Industry - Division of Industrial Relations - Workers' Compensation Section
Email Questions and Completed Forms to MedUnit@dir.nv.gov

REQUESTOR INFORMATION

Request Date	Requestor Type	Email
First Name	Last Name	Phone Number
Address	City	ST Zip

CLAIM INFORMATION

Insurer or TPA	Claim Nbr
Self-Insured Emp	Date of Injury
Employer	
Employee Name	SSN Birth Date
Employee City	ST Zip

REQUEST INFORMATION - If court ordered, decision MUST be attached

Stable and Ratable Date Received

Treating/Evaluating Physician(s)/
Chiropractic Physician(s)

USE MOST SPECIFIC BODY PART CODE POSSIBLE -- LIST ONLY CURRENT BODY PARTS TO BE RATED

Body Part Code

Injury Side

Diagnosis(es)

Comments

COMPLETE FOR PREVIOUS PPD EVALUATIONS ONLY

Prior Rating Physician(s)/Chiropractic
Physician(s)

Prior Treating Physician(s)/Chiropractic
Physician(s)

Reason for Additional PPD Request

COMPLETE FOR MUTUAL AGREEMENT ONLY

PPD Rating Physician/Chiropractic Physician: Last Name	First Name	License
Injured Employee/Representative:	Insurer/TPA Representative:	

THIS SECTION FOR WCS STAFF USE ONLY

Physician/Chiropractic Physician(s) Assigned	Physician/Chiropractic Physician(s) Phone
Assigned by	Date Assigned