

# 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
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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/Chiropractor: 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