State of Nevada ♦ Department of Business and Industry ♦ Division of Industrial Relations ♦ Workers' Compensation Section

REQUEST FOR A ROTATING RATING PHYSICIAN OR CHIROPRACTOR

Telephone 775-684-7265 Fax 775-687-6305

REQUESTOR INFORMATION

Request Date*		Requestor Type*	
First Name*		Last Name*	
Email(*)		Fax (*)	
Address Line 1*		City*	
Address Line 2*		Postal Code*	State*
Phone Number*			

CLAIM INFORMATION

Claim #*					
Insurer*					
Certificate#*		Insurer FEIN*		Insurer Type*	Other
Employer Name*					
Injured Employee*				Injured Employee SSN*	
Injured Employee City*				Injured Employee Postal Code*	
Date of Injury*					

REQUEST INFORMATION (If specialty is court ordered, decision MUST be attached)

Stable and Ratable Date Received*			
Treating & Evaluating Doctor(s)*			
Body Part Code/Description*	0000		
Injured Side*	◉ Left	○ Right	○ Both
Body Part Code/Description*	0000		
Injured Side*	◉ Left	○ Right	○ Both
Body Part Code/Description*	0000		
Injured Side*	◉ Left	○ Right	○ Both
Diagnosis*			
Doctor(s) who reviewed for possible PPD			

COMPLETE FOR ADDITIONAL REQUESTS ONLY (If specialty is court ordered, decision MUST be attached)

Date(s) of prior PPD Evaluation(s)	
Prior rating Doctor(s)	
Name of Treating Physician(s)/Chiropractor(s)	
Reason for Additional Request	

ASSIGNMENT/AGREEMENT OF RATER

Assigned or Agreed by:			
Physician/Chiropractor Assigned/Mutually Agreed to			
Physician/Chiropractor Assigned Phone #		Date of Assignment/Agreement	

*required fields. (*)requires one of the fields. Hard copy will not follow by mail.

Compliance with NAC 616C.103 is required.