BI-RIME

01/06

Request for Independent Medical Examination

Return completed form to:

BrickStreet Mutual Insurance
P. O. Box 3151
Charleston, WV 25332-3151

1. Claimant's Name

2. Claim Number

3. Social Security Number

4. Date of Injury

5. Body Part(s) to be examined

I, (write your name) ____ request to be sent out for an independent medical examination for an evaluation and determination regarding permanent partial impairment.

6. Mailing Address

7. Phone Number (include area code)

Claimant's Signature	**Date**