## INJURED WORKER INFORMATION

**Panel #:**

Date Request Received: Date Issued: No. of Req:

Claim No(s):

Date(s) of Injury:

Employer:

Ins./Adj. Agency:

**To:**

**Employee:**

*Defense Attorney:*

## SELECTED QUALIFIED MEDICAL EVALUATOR PANEL:

[ ] PHYSICIAN'S NAME
ADDRESS

Tel No.:

SPECIALTY
YEARS IN PRACTICE
PHYSICIAN'S EDUCATION

PHYSICIAN'S TRAINING

[ ] PHYSICIAN'S NAME
ADDRESS

Tel No.:

SPECIALTY
YEARS IN PRACTICE
PHYSICIAN'S EDUCATION

PHYSICIAN'S TRAINING

[ ] PHYSICIAN'S NAME
ADDRESS

Tel No.:

SPECIALTY
YEARS IN PRACTICE
PHYSICIAN'S EDUCATION

PHYSICIAN'S TRAINING