FORM ME-04

Independent Medical Examination (IME) – Employee's Ability to Resume Work or Employment

Instructions: An Independent Medical Examination (IME) may be requested for certain workmen's compensation matters. This IME form is specifically to evaluate and determine the employee's capacity and ability to resume work or employment. The Commission may require an employee to furnish an IME, or the employee may voluntarily do so on his own. If this particular IME is required, the employee must provide this form to an examining doctor or treating physician designated and authorized by the Commission to conduct such examination. It is the responsibility of the employee to facilitate all scheduling with the evaluating doctor for an examination and for such doctor to assist the employee on the requirement. The evaluating physician or doctor has 10-days after such examination to furnish his or her evaluation to the employee (including the Commission if applicable). The physician is also required to enclose his full evaluation report together with this form upon submission. Any cost associated in furnishing such evaluation must be geared directly to the requestor.

1. **Name of Injured Employee** (First, M. Last):	2. **Sex:** ☐ Male | ☐ Female	3. **Date of Injury:**	4. **Date of Examination:**
5. **Name of Designated Doctor Conducting Evaluation:**		6. **Physician's Specialization:**	

7. Examination Requested by Whom:

- ☐ Injured Employee
- ☐ Employer / Insurance Carrier
- ☐ Workmen's Compensation Commission
- ☐ Administrative Law Judge / High Court

8. Indicate doctor's primary role in performing this evaluation:

- ☐ The employee's Primary Treating Physician (PTP)
- ☐ Designated by the Workmen's Compensation Commission
- ☐ Designated by treating physician to conduct such exam on his or her behalf

9. Location of Examination:

- ☐ LBJ – Fagaalu
- ☐ DOH Dispensary Clinic:
  - ☐ Manu'a – Ta'u
  - ☐ Manu'a – Ofu
  - ☐ Leone
  - ☐ Amouli
- ☐ Other (specify): _____

10. Specify all medical records used by the examiner to assess the employee's ability and capacity to resume work or employment:

- ☐ Employee's medical records (including CT scans, MRI, etc.)
- ☐ Employee's medical orders issued by the treating physician
- ☐ Other medical evaluations issued for the employee (e.g.; impairment eval; eval for medical retirement; etc.)
- ☐ Others (specify below):

11. Based on your examination, is the injured employee capable to return or resume work? Please select only one. Dates must be provided.

☐ YES – I hereby certify the employee to return or resume work full duties on or by the following date: _____ / _____ /_____

☐ YES – I hereby certify the employee to return or resume work but on light duties (with limiting tasks).

- The employee will be required to be re-evaluated for full duties by the following date: _____ / _____ /_____

☐ NO – I hereby certify that the employee has not reach capacity to return to work due to on-going disability and treatments.

- The employee may be re-evaluated for full duties by the following date: _____ / _____ /_____

☐ NO – Due to the employee's severe medical condition, the employee is no longer considered functional to resume any sort of work or employment.

12. **If you answered "No" to Question No. 11, specify all pending medical efforts remaining or required for the injured employee before returning to full duties. Please ensure to include and describe all such efforts within your submitted report.**

- ☐ Employee requires or has a scheduled surgery pending for the injury
- ☐ Employee requiring or expecting further medical treatments off-island (or LBJ's Off-Island Referral Program)
- ☐ Employee requiring or has not completed physical therapy
- ☐ Employee is recommended for a medical assessment for medical retirement
- ☐ Other (specify):

13. **Physician's Address**

Mailing Address:

14. **Physician's Contact Information:**

Work Tel: ( ) _____

Fax: ( ) _____

Email: _____

15. AUTHORIZATION:

I hereby affirm and certify that the information provided within this form, including the examiner's full medical evaluation report as enclosed together with this form, is both complete, accurate, and conforms with all the requirements set by the Workmen's Compensation Commission. I also acknowledge my authority and medical certification or qualified expertise to properly assess the employee's ability and capacity to return or resume work. I also understand that by making any misrepresentation on the claim or myself in the facilitation of this report is considered a crime, and any failure to provide this medical report as required before the Commission shall be considered an obstruction of the employee's workmen's compensation proceedings which shall be punishable before the High Court of American Samoa as prescribed under Title 32: Chapter 5; §32.0550 of the A.S.C.A.

(Sign Here): _____

Physician's Authorized Signature

_____

Date