FORM ME-03

PETITION REQUEST FOR A SECONDARY MEDICAL OPINION ON DISABILITY

<u>Instructions:</u> Pursuant to A.S.C.A. §32.0619(e), the Commissioner has the authority to cause an injured employee to be re-examined by a designated physician if, in the opinion of the Commissioner, the first evaluation failed to impartially estimate the degree of the employee's permanent disability or the extent of temporary disability. Nonetheless, an employee may petition the Commissioner to consider a secondary medical opinion. To file a petition, the employee must file this form with the Commission's Office.

• If a second evaluation finds the estimate of such physician has not been impartial, the Commissioner shall charge the cost of such examination to the employer or insurance carrier; otherwise, the injured employee shall bear the full cost of such exam if the physician's estimate is deemed impartial.

| 1. | Date of this Request: | 2. Name of Injured Employee: | | 3. Name of Employer | |
|---|--|------------------------------|---------------------|--|--|
| 4. | Date of First Disability Impairment I | Evaluation: | 5. Name of Doctor / | Physician Conducting First Evaluation: | |
| 6. | 6. Indicate Reason(s) for a Secondary Medical Opinion: | | | | |
| ☐ Impairment percentage rating issued does not estimate the full degree of injury; | | | | | |
| Medical examination and evaluation on the impairment was bias (Employee required to provide proof); | | | | | |
| Physician conducting examination and evaluation was unqualified (Employee required to provide proof); | | | | | |
| Physician was not using guidelines allowed by the Commission for permanent impairment evaluation; | | | | | |
| Other reasons – specify below: | | | | | |
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| 7. | Authorization: | | | | |
| | | | | | |
| (Sign I Auth | Here): orized Signature of Employee | | | | |

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FORM ME-03 ON | REV.: 02-05-24 Page 1 of 1