

BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

_____	No(s): _____
vs. _____ Claimant(s),	_____
_____ Employer,	
_____ Insurance Carrier,	Answer Concerning
_____ Defendant(s).	Independent Medical Examination

1. Employer's name: _____
2. Employer's address: _____
3. Insurance carrier's name: _____
4. Insurance carrier's address: _____
5. Employer/insurance carrier admit the allegations contained in the following paragraphs of the petition:

6. Employer/insurance carrier deny the allegations contained in the following paragraphs of the petition:

7. Employer/insurance carrier:
☐ Consent to pay the reasonable expenses of the requested examination.
☐ Do not consent to pay the expenses of the requested examination for the following reason(s):
8. Employer/insurance carrier:
☐ Waive an evidentiary hearing under Iowa Code section 17A.12.
☐ Request an evidentiary hearing.

Signature of Attorney for Defendant(s) - or - Representative of Defendant(s)

Full Name: _____
Law Firm/Entity: _____
Telephone: _____
Email: _____
Mailing Address: _____

CERTIFICATE OF SERVICE

I, _____, hereby certify that a copy of this document was served upon counsel of record for each party or each self-represented party to this case on the date of _____, by:

☐ Iowa Workers' Compensation Electronic System (WCES).

☐ Other: _____

Signature

Date



Iowa Department of **INSPECTIONS APPEALS & LICENSING**
Division of **WORKERS' COMPENSATION**
Answer Concerning Independent Medical Examination
Form 100A (14-0007A) — Last Updated July 1, 2023
www.iowaWorkComp.gov

