Department of Labor and Industries
Provider Review & Education Unit
PO Box 44322
Olympia WA 98504-4322

INDEPENDENT MEDICAL EXAM COMMENTS

Please use the block below to provide us your comments, positive or negative, about your recent IME. Thank you.

Date of Exam: _____ Claim # _____

IME Company Name (if known)

Name of Doctor(s)(if known) (1)	(2)

Comments: (please be specific)

Date	Signature