Case ID Number:
Employee Name:

Impairment Benefits Response Form

☒ **YES,** I wish to pursue a claim for impairment benefits for my accepted illness(es).

If you checked **YES** above, you must check one of the two options below and provide the necessary information:

☐ I want to have DEEOIC arrange for a qualified physician, known as a Contract Medical Consultant (CMC), to perform my impairment evaluation.

☒ I want to select my own qualified physician to perform my impairment evaluation. The physician's name, address and phone number is:

Physician Name: Dr. Loren Lewis
Address: PO Box 363
Nine Mile Falls, WA 99026
Phone No:(509) 531- 5992

☐ **NO,** I am not pursuing impairment benefits at this time. I understand that I can file for impairment benefits in the future by submitting a signed statement to that effect to the district office.

Signature (Required)

Signature *Date*

Mail EN-11A to: U.S. Department of Labor
OWCP/DEEOIC
P.O. Box 8306 London,
KY 40742-8306

Or you may fax it to: (720) 264-3099