

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:

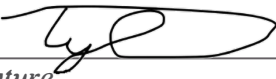
Physician Name: La Plata Medical Examiners (Damon Kalcich DO,
Bradley Campbell DO, Graham Tull MD)

Address: 783 NM 170
Farmington, NM 87401

Phone No:(505) 556-1999

☐ **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: (206) 224-1216

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Expiration Date: 05/31/2025

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