[Attorney Name]
[Law Firm Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Email]

[Date]

[Doctor Name]
[Office/Clinic Name]
[Address]
[City, State, Zip Code]

RE: Notice of Representation
Claimant: [Patient/Client Name]
Date of Birth: [DOB]
Date of Injury: [DOI]
Claim Number: [Claim Number]
Examination Date: [Date of Scheduled Exam]

Dear Dr. [Doctor Last Name],

Please be advised that this office represents the above-named claimant regarding their Workers' Compensation claim. We understand that you have been requested to perform an Independent Medical Examination (IME) of our client.

We kindly request that you provide our office with a complete copy of your formal narrative report and any findings immediately upon completion. If you have been provided with medical records or diagnostic films by the insurance carrier for review, please include a list of those specific materials in your report.

Furthermore, we request that you do not perform any invasive testing or procedures beyond the scope of a standard physical examination without prior written consent from our office. Our client has been instructed to cooperate fully with the physical examination and to provide an accurate history of the injury and symptoms.

Please direct all future correspondence regarding this examination, including billing for medical records or reports, to our office at the address listed above.

Thank you for your time and professional cooperation in this matter.

Sincerely,

[Signature]
[Printed Name]
[Law Firm Name]

cc: [Insurance Carrier/Adjuster Name]