CC-FORM-626

MEDICAL CASE MANAGER APPLICATION

☐ Initial Application
☐ Renewal

Please complete the following, sign under PENALTY OF PERJURY and return with a current resume to the:

WORKERS' COMPENSATION COMMISSION
ATTENTION: HEALTH SERVICES DIVISION
1915 NORTH STILES AVENUE
OKLAHOMA CITY, OKLAHOMA 73105

ALL INFORMATION SUBMITTED TO THE COMMISSION MAY BE CONSIDERED A PUBLIC RECORD UNDER STATE LAW. Direct all questions concerning disclosures to the Commission's Health Services Division, (405) 522-3222 or In-State Toll Free, (855) 291-3612.

Applicant's Name:	Name of Place of Business:	THIS SPACE FOR OFFICE USE ONLY
Office Address: City State Zip		
Mailing Address: City State Zip		
E-Mail Address of Applicant:		
Office Phone:	Name of Contact Person to Confirm Availability for Commission Appointment:	

1. Professional Credentials ☐R.N. (Oklahoma License No. _____) ☐CDMS ☐CCM ☐CRRN ☐CMC ☐COHN ☐COHN-S

(Attach a copy of your current professional license/case management certification, clearly marked as "COPY.")

NOTE: If you answer YES to question(s) 2, 3 and/or 4, provide an explanation on each on a separate sheet and attach to this application.

2. Has your professional license or case management certification ever been revoked or suspended by the issuer of the license or certification? ☐Yes ☐ No

3. Have you ever had any Disciplinary Actions, past or present, filed against you by your professional licensing body or case management certification entity? ☐Yes ☐No

4. Have you been convicted of a felony under federal or state law within 7 years before the date of this application? ☐Yes ☐No

5. Do you have any experience or education concerning workers' compensation principles or the Oklahoma workers' compensation system? ☐Yes ☐No If yes, please list:_____.

6. List types of medical cases you do NOT want referred to you: _____.

7. Do you do telephone case management? ☐Yes ☐No If yes, what are your estimated fees? _____.

8. Do you provide in-person case management services? ☐Yes ☐No If yes, list city(ies) in which you will provide in-person case management services: _____.

   If you provide in-person case management services, what are your estimated fees? _____.

9. Attach a list of each employer, insurer, employer group, certified workplace medical plan, or any representative thereof with whom you are under contract as a case manager or who regularly uses your case management services. (Please type or print.)_____

   _____

I request appointment to the list of Medical Case Managers maintained by the Oklahoma Workers' Compensation Commission. I will provide independent, impartial and objective medical case management services in all cases to which I am assigned. I will decline a request to serve as a medical case manager only for good cause shown. I will meet with the worker and appear at appointments by treating physicians as directed by the Commission and as necessary to report findings or respond to questions and issues submitted by the Commission. I will submit an initial written report within twenty calendar days of the order appointing me as the case manager, or sooner as the particular circumstances of medical care or Commission inquiries may necessitate. I will submit progress reports as necessary or as directed by the Commission. I will notify the Workers' Compensation Commission in writing upon any change affecting my qualifications as a medical case manager. If I am appointed to the list of Medical Case Managers, I agree to serve for a 2-year period. I agree to abide by all applicable statutes and workers' compensation rules and procedures.

I authorize all associations, organizations and State and Federal agencies to release to the Oklahoma Workers' Compensation Commission all relevant documents and information that may be required in the investigation of this application. I hereby certify that my professional license/certification as a case manager is in good standing.

I declare under PENALTY OF PERJURY that the statements contained herein are true and correct to the best of my knowledge and belief. I understand that false or misleading information may result in the rejection of my application or my removal from the list if I am appointed.

SIGNATURE _____ **DATE** _____