CC-FORM-463

Application for INDEPENDENT MEDICAL EXAMINER

☐ Initial Application
☐ Renewal

Please complete a Commission CC- Form-17, "Disclosure Statement", and the following, sign under PENALTY OF PERJURY and return with current Curriculum Vitae to the:

WORKERS' COMPENSATION COMMISSION
ATTENTION: Health Services Division
1915 North Stiles Avenue, Oklahoma City, OK 73105

ALL INFORMATION SUBMITTED TO THE COMMISSION MAY BE CONSIDERED A PUBLIC RECORD UNDER STATE LAW. Direct all questions concerning disclosures to the Health Services Division.

Physician Name:	Group/Clinic Name:	Office Hours:
Office Address (include multiple states if applicable): City State Zip		Office Phone
Mailing Address: City State Zip		E-Mail Address
Name of Contact Person to schedule appointments (Include telephone number if different from office phone):		In which City are Examinations performed:

THIS SPACE FOR COMMISSION USE ONLY

1. Professional Degree: M.D. ☐ D.O. ☐ D.C. ☐ D.P.M. ☐ D.D.S ☐ O.D. ☐ Ph.D. ☐
   Board Certification: _____
2. Oklahoma Professional Registration/License # _____; Licensed to practice in which State(s)?_____; Years in Practice: _____
3. If authorized by law to prescribe, administer and dispense narcotics and dangerous drugs please provide a copy of valid Oklahoma BNDD registration (or comparable registration from the state where the physician is licensed and practices, if different from Oklahoma) and Federal DEA registration.
4. Primary Specialty (List specific body parts): _____
5. List specific body parts or types of medical cases you do NOT want referred to you: _____
   _____
6. Application to: Treat?_____ Rate PPD/PTD?_____ Rate in Combined Disability cases? _____
7. Attach a copy of your current certificate of coverage for health care provider professional liability insurance in accordance with Commission Rule 810:15-9-1. (The insurer must be authorized to transact insurance in the state where the physician practices.)
8. Current Hospital Privileges and/or Teaching Positions: (If no current hospital privileges, please explain by separate attachment.) _____
   _____

NOTE: If you answer YES to question(s) 9, 10, 11, and/or 12, please provide an explanation of each on a separate sheet and attach to this application.

9. Have your Hospital Privileges ever been revoked or suspended in Oklahoma or any other State? YES ☐ NO ☐
10. Have you had any Disciplinary Actions, past or present, filed against you by your professional licensing body? YES ☐ NO ☐ If yes, please list, including the year: _____
11. Has your medical license ever been suspended, revoked or restricted by any State? YES ☐ NO ☐
12. Have you been convicted of a felony under federal or state law within 7 years before the date of this application? YES ☐ NO ☐
13. Please list any experience or education concerning workers' compensation principles of the Oklahoma Workers' Compensation system. _____
    _____
14. List any IME training you have attended:_____
    _____

I request appointment to the list of Independent Medical Examiners maintained by the Oklahoma Workers' Compensation Commission. I will provide independent, impartial and objective medical findings in all cases that come before me. I will decline a request to serve as an independent medical examiner only for good cause shown. I will conduct an examination, if necessary, within forty-five calendar days from the order appointing me in the case, unless otherwise approved by the Commission when necessary to render findings on the questions and issues submitted. I will submit a written report within fourteen calendar days following receipt of all necessary records and information, the completion of an examination, or the completion of any required tests, whichever is applicable. I will accept the fees established pursuant to Commission Rule 810:15-9-5 as payment in full for services rendered as an independent medical examiner. I will submit to a review pursuant to 85A O.S., §112(H) and Commission Rule 810:15-9-3. If I am appointed to the list of Independent Medical Examiners, 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 Workers' Compensation Commission all relevant documents and information that may be requested in the investigation of this application. I hereby certify that my medical license is in good standing.

_____ SIGNATURE

_____ DATE

Revised 4-7-14