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FOR DWC USE ONLY
QME NO.:_____
INPUT DATE:_____
INPUT BY:_____

APPLICATION FOR APPOINTMENT AS QUALIFIED MEDICAL EVALUATOR

Administrative Director
Division of Workers' Compensation-Medical Unit
P.O. Box 71010
Oakland, CA 94612

SECTION 1 (FOR ALL APPLICANTS COMPLETION OF THIS FIELD IS REQUIRED) PLEASE TYPE OR PRINT LEGIBLY

Please list your primary location. DO NOT USE P.O. BOX. Office locations may be added when your fee assessment is paid. You will be billed shortly after passing the QME test.

Last Name | First Name | MI | Suffix

Contact Address (Use licensing board contact address) | City | State | Zip + 4

Business Phone (Use Area Code and number) (Required) | Business- E-mail Address (optional) | California Professional License Number *(Required)* | License Expiration Date (MM/DD/YYYY) *(Required)* | Year Entered Practice *(YYYY)(Required)*

SECTION 2 (FOR ALL APPLICANTS) IMPORTANT: This section must be fully completed before proceeding. *PROFESSIONAL EDUCATION INDICATE DEGREE OBTAINED (e.g. M.D., D.O., D.C., Ph.D., Psy.D., Ed.D., etc.)* COLLEGE, UNIVERSITY OR MEDICAL SCHOOL

City | State | Country | Date of Degree | Degree

SECTION 3 (FOR M.D.'s AND D.O.'s ONLY) POSTGRADUATE TRAINING *NOTE: For M.D.s or D.O.s who are not board certified, state law requires successful completion of a residency training program accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association. DO NOT ENTER "SEE RESUME".*

Type | RESIDENCY: Name of sponsoring institution | City | State | From | To

Type | RESIDENCY: Name of sponsoring institution | City | State | From | To

Type | Fellowship: Name of sponsoring institution | City | State | From | To

Indicate whether you are certified by a specialty board recognized by the Medical Board of California or the Osteopathic Medical Board of California or have qualifications deemed to be equivalent to board certification in a specialty by the Medical Board of California or the Osteopathic Medical Board of California .

Specialty or subspecialty certification | Expiration Date | Specialty or subspecialty certification | Expiration Date

Specialty or subspecialty certification | Expiration Date | Specialty or subspecialty certification | Expiration Date

IMPORTANT: *IF THE M.D. OR D.O. IS BOARD CERTIFIED, PLEASE PROVIDE COPY OF BOARD CERTIFICATE(S). OTHERWISE, PLEASE PROVIDE COPY OF CERTIFICATE(S) OF COMPLETION OF POSTGRADUATE TRAINING.*

SECTION 4 (FOR M.D.s AND D.O.s ONLY) NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS

1) I am board certified in the specialty for which I am applying to become a QME by a board recognized by the Administrative Director and the Medical Board of California or the Osteopathic Medical Board of California. ☐

2) I completed postgraduate training in the specialty at an institution recognized by the ACGME or the American Osteopathic Association. ☐

3) I have qualifications that the Administrative Director and the Medical Board of California or the Osteopathic Medical Board of California both deem to be equivalent to board certification in a specialty. (Please submit documentation from the Medical or Osteopathic Board.) ☐

SECTION 5 (FOR Ph.D.'s, Psy.D.'s AND Ed.D.'s ONLY) NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS

1) I am board certified in clinical psychology by the American Board of Professional Psychology and have five (5) years doctoral experience. ☐

2) I have a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology, from a university or professional school recognized by the Administrative Director and have not less five than years postdoctoral experience in the diagnosis and treatment of emotional and mental disorders. ☐

3) I have not less than five years postdoctoral experience in the diagnosis and treatment of emotional and mental disorders and I have served as an Agreed Medical Evaluator (AME) on eight or more occasions prior to January 1, 1990. *(Please provide documentation of 8 AMEs, i.e. AME cover letters, first page of the reports, or a sworn statement made under penalty of perjury.)* ☐

SECTION 6 (FOR D.C.'s ONLY) NOTE: APPLICANT MUST MEET THE FOLLOWING REQUIREMENT

I am certified in California workers'compensation evaluation by either a California professional chiropractic association or an accredited California college recognized by the Administrative Director (i.e. Industrial Disability Evaluation Certificate [min. 44 hrs.]). ☐

SECTION 7 (FOR ALL APPLICANTS) NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS

1) I devote at least one-third of my total practice time to providing direct medical treatment (direct medical treatment is that special phase of the physician-patient relationship during which the physician: (1) attempts to clinically diagnose and to alter or modify the expression of a non-industrial illness, injury or pathological condition; or (2) attempts to cure or relieve the effects of an industrial injury.) ☐

2) I have served as an Agreed Medical Evaluator (AME) on eight (8) or more occasions in the 12 months prior to submitting this application. (Submit documentation of 8 AMEs, i.e. AME cover letters, first page of reports or a sworn statement made under penalty of perjury.) ☐

SECTION 8 (FOR ALL APPLICANTS) PLEASE INDICATE THE SPECIALTY(IES) FOR WHICH YOU ARE APPLYING TO DO QME EXAMS- REFER TO ATTACHED SPECIALTY CODES

Professional practice specialty code (Required)	Professional practice specialty code
Professional practice specialty code	Professional practice specialty code

SECTION 9 (FOR ALL APPLICANTS, IF COURSE COMPLETED) I certify that I have completed a disability evaluation report writing course approved by the Administrative Director

Course _____ Date of Course _____

SECTION 10 (FOR ALL APPLICANTS) Affirmations: (Initialing each box affirms that you have read and agree to each of the statements. Do not initial if your statement is untrue. Attach an explanation on a separate piece of paper.)

INITIALS

A. **License Status.** I certify that no disciplinary action has ever been taken against my California license to practice as a physician, and that my license is active and neither restricted nor encumbered by suspension, interim suspension or probation. I agree to promptly notify the DWC Medical Unit of any future disciplinary action taken against me by my licensing agency. *(Do not initial if either statement is untrue. Attach an explanation on a separate piece of paper.)* ☐

B. **Convictions.** I certify that I have never been convicted of a misdemeanor felony related to my practice, or for a crime of moral turpitude. I agree to promptly notify the DWC Medical Unit of any future practice-related conviction, or conviction for a crime of moral turpitude. *(Do not initial if either statement is untrue. Attach an explanation on a separate piece of paper. Convictions expunged under Penal Code § 1203.4 must be disclosed.)Do not initial if either statement is untrue. Attach an explanation on a separate piece of paper.)* ☐

C. **Prohibited Activities**. I agree that I shall abide by all Administrative Director regulations. I will not refer patients to facilities in which I or my family members have a financial interest, except as permitted by law. I agree that I shall not offer, deliver, receive or accept any rebate, refund, commission,preference, patronage, dividend,discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred evaluation or consultation. I agree not to solicit to provide medical treatment to an injured employee for any injury for which I have done a QME evaluation. ☐

INITIALS

D. I have not performed a QME evaluation prior to appointment as a QME by the Administrative Director. I have accurately and fully reported all specified financial interests that may affect the fairness of QME panels, as required on the attached QME SFI Form 124.

Verification I have used all reasonable diligence in preparing and completing this application. I have reviewed this completed application and to the best of my knowledge the information contained herein and in the attached supporting documentation is true, correct and complete. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. *(Failure to provide truthful information shall result in denial of applicant's appointment and/or disciplinary action.)*

Executed on: _____ _____ , _____
at State

_____
Applicant's signature

IMPORTANT: Your application for appointment as a QME shall be returned if it is incomplete. Please check:

1) That your application is fully completed, dated and signed with an original signature. We will not accept faxed applications.

2) All necessary documentation is attached:

a) All applicants: A Copy of your current California Professional License.

b) M.D.'s, D.O.'s: A copy of your board certificate(s) and certificate(s) completion of residency and fellowship training program(s) by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association. Please provide a copy for *each* specialty in which you are requesting appointment to perform QME Exams.

c) D.C.'s: A copy of your certificate in California Workers' Compensation Evaluation .

d) Ph.D.'s, Psy.D.'s and Ed.D.'s: A copy of your professional diploma(s). A copy of board certification, if appropriate.

e) ALL OTHERS: A copy of your professional diploma(s) and California License.

f) A copy of the completion certificate from the report writing course is required by title 8 Cal. Code Regs. §11.5, once completed. ***This document must be submitted prior to obtaining your appointment as a QME.***

g) A completed, signed QME SFI Form 124. (QME Disclosure of Specified Financial Interests That May Affect the Fairness of QME Panels. ***This document must be submitted prior to obtaining your appointment as a QME.***

A PUBLIC DOCUMENT

PRIVACY NOTICE - The Information Practices Act of 1977 and the Federal Privacy Act require the Administrative Director to provide the following notice to individuals who are asked by a governmental entity to supply information for appointment as a Qualified Medical Evaluator(QME).

The principal purpose for requesting information from QME's is to administer the QME program within the California workers' compensation system. Additional information may be requested if your application is denied and/or a disciplinary action is taken.

The California Labor Code requires every QME physician to meet certain statutory requirements. Physicians are required by the Labor Code to provide: name; business address/addresses; professional education; training; license number; year entered practice and other requirements deemed necessary by the Administrative Director. It is mandatory to furnish all the appropriate information requested by the Administrative Director. Failure to provide all of the requested information may result in the denial of the application.

As authorized by law, information furnished on this form may be given to: you, upon request; the public, pursuant to the Public Records Act; a governmental entity, when required by state or federal law; to any person, pursuant to a subpoena or court order pursuant to any other exception in Civil Code § 1798.24.

An individual has a right of access to records containing his/her personal information that are maintained by the Administrative Director. An individual may also amend, correct, or dispute information in such personal records (Civil Code § 1798.34-1798.37).

Requests should be sent to: Division of Workers' Compensation-Medical Unit
P.O. Box 71010
Oakland, CA 94612
Tel: (510) 286-3700 or (800) 794-6900
Fax: (510) 622-3467

You may request a copy of the Division of Workers' Compensation policy and procedures for inspection of records at the above address. Copies of the procedures and all records are ten cents ($0.10) per page, payable in advance. (Civil Code § 1798.33).

For Use on the QME Application Form 100

IMPORTANT: PLEASE USE THREE LETTER SPECIALTY CODE WHEN COMPLETING BLOCK 8 OF APPLICATION FORM

MD/DO SPECIALTY CODES

MAI Allergy & Immunology

MAA Anesthesiology
MPA Pain Medicine

MDE Dermatology

MAI Dermatology - Allergy & Immunology

MEM Emergency Medicine

MTT Emergency Medicine - Toxicology

MFP Family Practice

MPM General Preventive Medicine

MTT General Preventive Medicine – Toxicology

MMM Internal Medicine

MAI Internal Medicine - Allergy & Immunology

MMV Internal Medicine - Cardiovascular Disease

MME Internal Medicine – Endocrinology Diabetes & Metabolism

MMG Internal Medicine - Gastroenterology

MMH Internal Medicine - Hematology

MMI Internal Medicine - Infectious Disease

MUU Urology

MMN Internal Medicine - Nephrology

MMP Internal Medicine - Pulmonary Disease

MMR Internal Medicine - Rheumatology

MPN Neurology

MPA Neurology - Pain Medicine

MNS Neurological Surgery (other than Spine)

MNB Neurological Surgery – Spine

MOG Obstetrics & Gynecology

MOQ Medicine Otherwise Qualified

MPO Occupational Medicine

MTT Occupational Medicine – Toxicology

MOP Ophthalmology

MOS Orthopaedic Surgery (other than Spine or Hand)

MNB Orthopaedic Surgery - Spine

MHH Orthopaedic Surgery – Hand

MTO Otolaryngology

MHA Pathology

MPR Physical Medicine & Rehabilitation

MPA Physical Medicine & Rehabilitation – Pain Medicine

MPS Plastic Surgery (other than Hand)

MHH Plastic Surgery - Hand

MPD Psychiatry (other than Pain Medicine)

MPA Psychiatry – Pain Medicine

MSY Surgery (other than Spine or Hand)

MHH Surgery - Hand

MSG Surgery - General Vascular

MTS Thoracic Surgery

MUU Urology

NON-MD/DO SPECIALTY CODES

ACA Acupuncture

DCH Chiropractic

DEN Dentistry

OPT Optometry

POD Podiatry

PSY Psychology