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REAPPOINTMENT APPLICATION 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 these fields is required) ***PLEASE TYPE OR PRINT LEGIBLY***

Last Name | First Name | MI | Suffix

Contact Address (Use license board contact address) | City | State | Zip Code

Business Phone (Use Area Code then the 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 M.D.'s AND D.O.'s ONLY) 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. *(If you became board certified after your last QME appointment, you must attach a copy of the certificate of board certification.)* ☐

Specialty or subspecialty certification | Expiration Date (mm/dd/yyyy) | Specialty or subspecialty certification | Expiration Date (mm/dd/yyyy)

Specialty or subspecialty certification | Expiration Date (mm/dd/yyyy) | Specialty or subspecialty certification | Expiration Date (mm/dd/yyyy)

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 deemed to be equivalent to board certification in a specialty. (Please submit documentation from the Medical or Osteopathic Board.) ☐

Specialty or subspecialty certification | Expiration Date (mm/dd/yyyy) | Specialty or subspecialty certification | Expiration Date (mm/dd/yyyy)

4) I was an active qualified medical evaluator on June 30, 2000. ☐

Section 3 (FOR ALL APPLICANTS) 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: (a) attempts to clinically diagnose and to alter or modify the expression of a non-industrial illness, injury or pathological condition; or (b) 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 the12 months prior to submitting this application. *(Submit documentation of 8 AME cover letters, first page of reports or a sworn statement made under penalty of perjury.)* ☐

3. I am currently a salaried faculty member at an accredited university or college. I have a current California license to practice as a physician and have been engaged in teaching, lecturing, published writing or medical research at that university or college in my area of specialty for not less than one-third of my professional time. My practice in the three consecutive years immediately preceding the time of application was not devoted solely to the forensic evaluation of disability. *(Please submit evidence of your faculty appointment.)* ☐

4. I am retired from active practice. I have a minimum of 25 years' experience in practice as a physician and, currently, I practice fewer than 10 hours per week on direct medical treatment as a physician. My practice in the three consecutive years immediately preceding the time of reappointment was not devoted solely to the forensic evaluation of disability. ☐

5. I am retired from active practice due to a documented medical or physical disability as defined by Government Code §12926 and currently practicing in my specialty fewer than 10 hours per week. I have 10 years' experience in workers' compensation medical issues as a physician. My practice in the three consecutive years immediately preceding the time of application was not devoted solely to the forensic evaluation of disability. *(Please submit medical documentation of your disability.)* ☐

Section 4 (FOR ALL APPLICANTS) (FOR ALL APPLICANTS) PLEASE INDICATE THE SPECIALTY(IES) FOR WHICH YOU ARE APPLYING TO DO QME EXAMS-USE ENCLOSED REFER TO ATTACHED SPECIALTY CODES

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

Professional practice specialty code | Professional practice specialty code

Section 5 (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 explanation on a separate piece of paper. Failure to do so may result in disciplinary action by the Administrative Director.)* ***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 or a 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. ☐

Section 6 (FOR ALL APPLICANTS) Continuing Education Courses *(List the continuing education courses you have completed within the last 24 months)*

Provider Name	Course Name	Course Date (mm/dd/yyyy)	Credit hours
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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

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 QMEs 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 or 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). 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

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

For Use on the QME Application Form 104

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

MD/DO SPECIALTY CODES

MAI Allergy & Immunology

MAA Anesthesiology

MPA ~~Anesthesiology~~ - 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

MMG Internal Medicine - Gastroenterology

MMH Internal Medicine - Hematology

MMI Internal Medicine - Infectious Disease

MMO Internal Medicine - Medical Oncology

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

~~MMO Orthopaedic Surgery - Oncology~~

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

~~MMO Radiology - Oncology~~

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

~~PSN Psychology - Clinical Neuropsychology~~