PHYSICIAN CONTRACT APPLICATION
(INDEPENDENT MEDICAL REVIEWER)
For the Department of Industrial Relations
Division of Workers' Compensation
P.O. Box 8888
San Francisco, CA 94128-8888

PRINT CLEAR

FOR OFFICE USE ONLY
NO.:
INPUT DATE:
INPUT BY:

BLOCK 1

PLEASE TYPE OR PRINT LEGIBLY

Please list your primary location. DO NOT USE P.O. BOX. You may provide additional office addresses at which you may schedule appointments, on a separate sheet.

LAST NAME	FIRST NAME	MI	JR/SR

BUSINESS ADDRESS	CITY	ZIP+4

MAILING ADDRESS, if different from above	CITY	ZIP+4

E-MAIL ADDRESS

(AREA CODE) PHONE NO.	(AREA CODE) FAX NO.	CAL. PROFESSIONAL LICENSE NUMBER	EXPIRATION (MM/YY)

BLOCK 2

MEDICAL/GRADUATE SCHOOL

CITY	STATE	DEGREE	DATE OF DEGREE

ALL PHYSICIANS are to furnish their board certification and current hospital privileges, if applicable.
PLEASE LIST:

Hospital/Facility	Location (City/State)	Type	From	To
Hospital/Facility	Location (City/State)	Type	From	To

BLOCK 3 PHYSICIANS MUST MEET THE FOLLOWING REQUIREMENTS

	Yes	No
1) I am board certified in a specialty recognized by the appropriate California licensing Board. List name(s) of board: _____	☐	☐

2) Date of expiration of board certification, if applicable _____

3) List the requested specialty codes using the three digit specialty codes listed on page 5 _____

BLOCK 4

Physicians are prohibited from serving as an IMR in cases in which they have a material professional, familial, or financial affiliation with any of the parties or companies involved. YOU are responsible for determining whether you have one of these affiliations in any particular case, and for recusing yourself, although the Administrative Director will attempt to screen out any cases in which a conflict of interest is apparent from the names of all companies with which you have a material professional, familial or financial affiliation, as defined in the Regulations. **Please list entities with which you have an affiliation, and respond "not applicable" if appropriate.**

Workers' Compensation Insurance Companies

1.	3.
2.	4.

Workers' Compensation Third Party Administrators

1.	3.
2.	4.

Utilization Review Companies

1.	3.
2.	4.

Medical Provider Networks (Name or MPN number)

1.	3.
2.	4.

Hospitals or Ambulatory Surgery Centers (Please include the address(es) of the facility)

1.	3.
2.	4.

Drugs, Devices, Procedures or Therapies

1.	3.
2.	4.

** PROVIDE ADDITIONAL SHEETS WHEN NECESSARY**

BLOCK 5 PLEASE CHECK:

1) That the physician sections of this contract are fully completed, dated and signed with an original signature. We will not accept faxed applications.
2) That all necessary documentation is attached:
   - A Copy of your current California Professional License.
   - A Copy of your board certification(s).
   - Certification of your current hospital privileges, if applicable.

IMPORTANT: Your contract application to be an Independent Medical Review Physician shall be returned if it is incomplete, and it must be submitted prior to obtaining your appointment.

BLOCK 6	Yes	No
License Status		
1) Have you ever been formally disciplined by any State Medical Licensing Board? *If the answer is "Yes", please furnish full particulars on a separate sheet.	☐	☐
2) Is any accusation by any State medical licensing board for a quality of care violation, fraud related to medical practice, or felony conviction or conviction of a crime related to the conduct of your practice of medicine currently pending against you? *If the answer is "Yes", please furnish full particulars on a separate sheet.	☐	☐
3) Have you ever lost hospital staff privileges? *If the answer is "Yes", please furnish full particulars on a separate sheet.	☐	☐
4) My license to practice medicine is active and is neither restricted nor encumbered by suspension, interim suspension or probation. *If the answer is "No", please furnish full particulars on a separate sheet.	☐	☐
5) I agree to notify the Administrative Director if my license to practice medicine is placed on suspension, interim suspension, probation or is restricted by my licensing agency, if my Board Certification is revoked, if my hospital staff privileges are revoked, or if I am convicted of a felony crime or a crime related to the conduct of my practice of medicine.	☐	☐

Verification

I understand that by submitting this contract application, I am offering to be an Independent Medical Reviewer. I have used reasonable diligence in preparing and completing this contract application. I have reviewed this completed contract application and to the best of my knowledge the information contained herein and in the attached supporting documentation is true, correct and complete. I understand that if this contract application is accepted that I will be placed on the list of eligible Independent Medical Reviewers. I understand that the Title 8, California Code of Regulations, sections 9768.1 et seq. set forth requirements that I must comply with and I agree to comply with those requirements. I understand that I must maintain the confidentiality of medical records and the review materials consistent with the applicable state and federal law. I confirm that I am familiar with the *American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines*, 2nd Edition (2004), published by OEM Press. If the Administrative Director adopts a medical treatment utilization schedule pursuant to Labor Code section 5307.27 during the two-year term of this contract, I agree to become familiar with that schedule no later than its effective date. I understand that this contract application is not accepted by the Administrative Director of the Division of Workers' Compensation until is it signed by the Administrative Director. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on _____ (MM/DD/YY) at _____ County CA _____ 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 an Independent Medical Reviewer physician.

The California Labor Code provides for physicians and surgeons to participate in the workers' compensation Independent Medical Reviewer program. The Division of Workers' Compensation has adopted regulations which require applicants under this program to provide: name; business address, professional education, training, license number, board certifications, fellowships, conflicts of interest, and documents deemed necessary by the Administrative Director of the Division of Workers' Compensation. It is mandatory to furnish all the appropriate information requested by the Administrative Director. This contract may not be accepted if all the requested information is not provided.

The principal purpose for requesting information from physicians and surgeons is to administer the Independent Medical Review program within the California workers' compensation system. Additional information may be requested.

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 of 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.)
Requests should be sent to:

Division of Workers' Compensation
P.O. Box 8888
San Francisco, CA 94128-8888

Copies of all records are ten cents ($0.10) per page, payable in advance. (Civil Code § 1798.33.)

ACCEPTANCE OF CONTRACT APPLICATION BY ADMINISTRATIVE DIRECTOR

The Administrative Director of the Division of Workers' Compensation accepts this contract application and agrees to add this physician's name to the list of eligible Independent Medical Reviewers for a two year term beginning with the date this contract is executed.

Executed on _____ (MM/DD/YY) at _____ County CA _____ Administrative Director

(Note to physicians: please use three letter specialty code when completing block 3 of application form)

SPECIALTY CODES

MAI	Allergy and Immunology
MAA	Anesthesiology
MRS	Colon & Rectal Surgery
MDE	Dermatology
MEM	Emergency Medicine
MFP	Family Practice
MPM	General Preventive Medicine
MOSU	Hand – Orthopaedic Surgery, Plastic Surgery, General Surgery
MMM	Internal Medicine
MMV	Internal Medicine – Cardiovascular Disease
MME	Internal Medicine – Endocrinology Diabetes and Metabolism
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
MNS	Neurological Surgery
MNM	Nuclear Medicine
MOG	Obstetrics and Gynecology
MPO	Occupational Medicine
MOP	Opthalmology
MOSG	Orthopaedic Surgery (General)
MOSS	Orthopaedic –Shoulder
MOSK	Orthopaedic –Knee
MOSB	Orthopaedic –Spine
MOSF	Orthopaedic –Foot and ankle
MTO	Otolaryngology
MAP	Pain Management –Psychiatry and Neurology, Physical Medicine and Rehabilitation, Anesthesiology
MHA	Pathology
MEP	Pediatrics
MPR	Physical Medicine & Rehabilitation
MPS	Plastic Surgery
MPD	Psychiatry
MSY	Surgery
MSG	Surgery – General Vascular
MTS	Thoracic Surgery
MTO	Toxicology – Preventive Medicine, Pediatrics, Emergency
MUU	Urology
MRD	Radiology
POD	Podiatry