

For Use on the QME Application Form  
IMPORTANT: PLEASE USE THREE LETTER SPECIALTY CODE WHEN  
COMPLETING BLOCK 8 OF APPLICATION FORM

**MD/DO SPECIALTY CODES**

MAI Allergy and Immunology  
MAA Anesthesiology  
MRS Colon & Rectal Surgery  
MDE Dermatology  
MEM Emergency Medicine  
MFP Family Practice - MD  
OFP Family Practice - DO  
OFM Family Practice - DO - Including Osteo-  
pathic Manipulation  
MPM General Preventive Medicine  
MOH Hand - Orthopaedic Surgery  
MPH Hand - Plastic Surgery  
MSH Hand - 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  
MOQ Medicine - Otherwise Qualified  
MPB Neurological Surgery-Including Back  
MPN Neurology  
MNS Neurological Surgery  
MNM Nuclear Medicine  
MOG Obstetrics and Gynecology  
MPO Occupational Medicine  
MOP Ophthalmology  
MOS Orthopaedic Surgery  
MOB Orthopaedic Surgery - Including Back  
MTO Otolaryngology  
MAP Pain Management - Anesthesiology  
MPP Pain Management - Pain Medicine  
MHA Pathology  
MEP Pediatrics  
MPR Physical Medicine & Rehabilitation  
MPS Plastic Surgery  
MPD Psychiatry  
MRY Radiology  
MSY Surgery  
MSG Surgery - General Vascular  
MTS Thoracic Surgery  
MPT Toxicology - Occupational Medicine  
MET Toxicology - Emergency Medicine  
MUU Urology

**NON-MD/DO SPECIALTY CODES**

\*denotes a doctor of chiropractic who  
has completed a chiropractic post-  
graduate specialty program

ACA Acupuncture  
DCH Chiropractic  
DCN Chiropractic - Neurology\*  
DCO Chiropractic - Orthopaedic\*  
DCR Chiropractic - Radiology\*  
DCS Chiropractic - Sports Medicine\*  
DCT Chiropractic - Rehabilitation\*  
DEN Dentistry  
OPT Optometry  
POD Podiatry  
PSY Psychology  
PSN Psychology - Clinical Neuropsychol-  
ogy



APPLICATION FOR APPOINTMENT AS QUALIFIED MEDICAL EVALUATOR

For the Department of Industrial Relations
Division of Workers' Compensation
P. O. Box 420603
San Francisco, CA 94142-0603

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

BLOCK 1 (FOR ALL APPLICANTS) PLEASE TYPE OR PRINT LEGIBLY

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

Form with fields for LAST NAME, FIRST NAME, MI, and JR/SR.

BUSINESS ADDRESS WHERE QME EVALUATIONS WILL TAKE PLACE

Form with fields for BUSINESS ADDRESS, CITY, and ZIP + 4.

MAILING ADDRESS FOR CORRESPONDENCE, IF DIFFERENT

Form with fields for MAILING ADDRESS, CITY, and ZIP + 4.

Form with fields for (AREA CODE) PHONE NO., CAL. PROFESSIONAL LICENSE NUMBER, EXPIRATION (MM/YY), and YEAR ENTERED PRACTICE.

PROCEED TO BLOCK 2

BLOCK 2 (FOR ALL APPLICANTS) IMPORTANT: BLOCK 2 Must be fully completed before proceeding. PROFESSIONAL EDUCATION INDICATE DEGREE OBTAINED (e.g. MD, DC, DO, Ph.D, Psy.D, Ed.D, etc.)

COLLEGE, UNIVERSITY or MEDICAL SCHOOL

Form with fields for COLLEGE, UNIVERSITY or MEDICAL SCHOOL, CITY, STATE, DATE OF DEGREE, and DEGREE. Includes instructions for MD, DC, DO, Ph.D, Psy.D, and Ed.D.

BLOCK 3 (FOR MDs AND DOs ONLY) POSTGRADUATE TRAINING:

NOTE: For MDs or DOs who are not board certified, state law requires successful completion of a residency training program accredited by the American Council on Graduate Medical Education or the American Osteopathic Association. Fellowships will not be accepted in lieu of accredited residency training.

DO NOT ENTER "SEE RESUME"

Form for PGY 1 or INTERNSHIP with columns for Hospital/Facility, Location (City/State), Type, Year From, and Year To.

Form for RESIDENCY with columns for Hospital/Facility, Location (City/State), Type, From, and To.

Form for RESIDENCY with columns for Hospital/Facility, Location (City/State), Type, From, and To.

Form for RESIDENCY with columns for Hospital/Facility, Location (City/State), Type, From, and To.

Form for FELLOWSHIP with columns for Hospital/Facility, Location (City/State), Type, From, and To.

IMPORTANT: IF APPLICANT IS BOARD CERTIFIED, PLEASE PROVIDE COPY OF BOARD CERTIFICATE(S). OTHERWISE, PLEASE PROVIDE COPY OF CERTIFICATE(S) OF COMPLETION OF POSTGRADUATE TRAINING.

PROCEED TO BLOCK 6 SUBMIT DOCUMENTATION

**BLOCK 4 (FOR DCs ONLY)**

**NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS**

**Yes No**

1) 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. IDE Certificate (min. 44 hrs. eff. 4/15/99)).

2) I have completed a chiropractic postgraduate specialty program of a minimum of 300 hours taught by a school or college recognized by the Administrative Director, the Board of Chiropractic Examiners and the Council on Chiropractic Education.

**PROCEED TO BLOCK 7      SUBMIT DOCUMENTATION**

**BLOCK 5 (FOR Ph.Ds, Psy.Ds AND Ed.Ds ONLY)**

**NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS**

**Yes No**

1) I am board certified in clinical psychology by the American Board of Professional Psychology, Inc.

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 than five 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).

**PROCEED TO BLOCK 7      SUBMIT DOCUMENTATION**

**BLOCK 6 (FOR MDs AND DOs ONLY)**

**NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS**

**Yes No**

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 Board).

**PROCEED TO BLOCK 7      SUBMIT DOCUMENTATION**

**BLOCK 7 (FOR ALL APPLICANTS)**

NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS

TRUE FALSE

- 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 health care provider-patient relationship which (1) attempts to clinically diagnose and 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.)

 
 

**PROCEED TO BLOCK 8**

**BLOCK 8 (FOR ALL APPLICANTS)**

PLEASE INDICATE SPECIALTY(IES) FOR WHICH YOU ARE APPLYING TO DO QME EXAMS (USE ENCLOSED SPECIALTY CODE LIST)

Professional practice specialty code:

Professional practice specialty code:

Professional practice specialty code:

Reminder: For MDs & DOs, a copy of your Board Certification or documentation of completion of a training program accredited by the American College of Graduate Medical Education or the American Osteopathic Association must be submitted. For DCs, a certificate from postgraduate specialty diplomate program must be submitted for each specialty.

**PROCEED TO BLOCK 9**

**BLOCK 9 (FOR ALL APPLICANTS, IF COMPLETED)**

I have completed a disability evaluation report writing course approved by the Administrative Director.

Course: \_\_\_\_\_ Date of Course: \_\_\_\_\_

**PROCEED TO BLOCK 10**

**BLOCK 10 (FOR ALL APPLICANTS)**

AFFIRMATIONS: Initialling each box affirms that you have read and agree to each of the statements.

INITIAL EACH BOX

**License Status**

A. My license to practice medicine is active and is neither restricted nor encumbered by suspension, interim suspension or probation. I certify that I have not been convicted of either a misdemeanor or felony related to my practice or a crime of moral turpitude.

B. 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. I further agree to notify the Administrative Director if I am convicted of a misdemeanor or felony related to my practice or a crime of moral turpitude. (Do not initial if your statement is untrue, attach an explanation on a separate piece of paper.) I understand that the Administrative Director may deny my application or conditionally accept my application if my license is on probation with my licensing authority.

**Financial Interest**

C. 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 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. I have not performed a QME evaluation prior to appointment as a QME by the Administrative Director.

**Cont'd of BLOCK 10 (FOR ALL APPLICANTS)****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. Failure to provide truthful information shall result in denial of applicants appointment and/or disciplinary action. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on  at  County CA  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. Please also submit statement of citizenship form.
- 2) All necessary documentation is attached:
  - a) All applicants - A Copy of your current California Professional License.
  - b) MDs, DOs - A copy of your board certification or certificate(s) of completion of a residency training program accredited by the American College of Graduate Medical Education or the American Osteopathic Association. Please provide for all specialties in which you are requesting appointment to perform QME exams.
  - c) DCs - A copy of your certificate in California Workers' Compensation Evaluation or a copy of your certificate from postgraduate specialty diplomate program. For DC specialties other than DCH (e.g. DCR) a copy of your certificate of completion of 300 hours from postgraduate specialty diplomate program is required.
  - d) Ph.D, Psy.D and Ed.D- A copy of your professional diploma(s). Copy of board certification, if appropriate.
  - e) ALL OTHERS - A copy of your professional diploma(s).
  - f) A copy of completion certificate from the report writing course required by Title 8 CCR §11.5, if completed.

**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 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).

Requests should be sent to:

Division of Workers' Compensation-Medical Unit  
 P.O. Box 420603  
 San Francisco, CA 94142-0603  
 Tel: (510) 286-3700 or 1(800) 794-6900  
 Fax: (510) 622-3467; E-mail: [www.dir.ca.gov](http://www.dir.ca.gov)

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).