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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

BLOCK 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. Additional 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 | JR/SR

Business Address (where QME Evaluations will Take Place) | City | State | Zip + 4

Mailing Address for Correspondence, if different | City | State | Zip + 4

Business Phone (Use Area Code then the number) | Business- Electronic Mail Address (optional) | California Professional License Number *(Required)* | License Expiration Date (MM/DD/YYYY) *(Required)* | Year Entered Practice

BLOCK 2 (FOR ALL APPLICANTS) IMPORTANT: BLOCK 2 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

BLOCK 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. Fellowships will not be accepted in lieu of accredited residency training. DO NOT ENTER "SEE RESUME".*

PGY 1 or INTERNSHIP: Hospital/Facility | City | Type | State | From | To

RESIDENCY: Hospital/Facility | City | Type | State | From | To

RESIDENCY: Hospital/Facility | City | Type | State | From | To

RESIDENCY: Hospital/Facility | City | Type | State | From | To

RESIDENCY: Hospital/Facility | City | Type | State | From | 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.

BLOCK 4 (FOR D.C.'s ONLY) NOTE: APPLICANT MUST MEET THE FOLLOWING REQUIREMENTS

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.]). ☐

BLOCK 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 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.)* ☐

BLOCK 6 (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.) ☐

BLOCK 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.) ☐

BLOCK 8 (FOR ALL APPLICANTS) PLEASE INDICATE THE SPECIALTY(IES) FOR WHICH YOU ARE APPLYING TO DO QME EXAMS-USE ENCLOSED

Professional practice specialty code _____ ▼

Professional practice specialty code _____ ▼

Professional practice specialty code _____ ▼

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

Course _____ Date of Course _____

BLOCK 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.)***

A. License Status and Convictions *(Present and past)* My California license to practice as a physician 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 misdemeanoror felony related to my practice or for a crime of moral turpitude. *(Do not initial if either statement is untrue. Attach an explanation on a separate piece of paper.)* ☐

B. License Status and Convictions *(Future changes)* I agree to notify the Administrative Director if my California license to practice 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 o my practice or a crime of moral turpitude. 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. ☐

C. Referrals; Specified Financial Interests *(Other 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.

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 certification or certificate(s) of completion of a residency training program accredited 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
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 & 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
MPA Neurology - Pain Medicine
MNS Neurological Surgery (other than Spine)
MNB Neurological Surgery – Spine
MOG Obstetrics & Gynecology
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
MPA Pain Medicine
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
AUD Audiology
DCH Chiropractic
DEN Dentistry
OPT Optometry
POD Podiatry
PSY Psychology
PSN Psychology - Clinical Neuropsychology