



Northern Ohio Medical Management Corporation

803 E. Washington Street, #150

Medina, Ohio 44256

Telephone: 330 273-3624

Fax: 866 878-6543

[www.nommc.com](http://www.nommc.com) [info@nommc.com](mailto:info@nommc.com)

## IME Physician Panel Application

**Instructions:**

- Please print or type
- The completed application and support documentation must be signed and returned to NOMMC at the above address. For any questions, please feel free to contact us at (330) 273-3624.
- If there are other physicians in your practice who perform Independent Medical Exams, they must complete a separate application.
- **Please include a copy of the following:**
  - ✓ Curriculum Vita
  - ✓ Liability Insurance Coverage
  - ✓ 3 sample IME reports
  - ✓ Board and Academy Certifications
  - ✓ Medical License(s)
  - ✓ Map and Directions to Office location(s)

Physician Information			
First Name	M.I.	Last Name	Professional Title <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> D.C. <input type="checkbox"/> Ph.D. <input type="checkbox"/> D.D.S. <input type="checkbox"/> D.P.M.
Are you a certified workers compensation provider in your state? <input type="checkbox"/> Yes <input type="checkbox"/> No			Specialty(s):
Are you currently a panel physician for disability evaluations? <input type="checkbox"/> Yes <input type="checkbox"/> No			Tax I.D. Number:
<b>Primary Examination Location</b> – where examinations will be provided. If there are additional offices where you perform exams, please attach a separate page with a listing of each office address and telephone number.			
Street Address		Suite, floor, etc.,	
City		State	Zip Code
Telephone number (     )		Fax Number (     )	

**Please select the services that you are interested in performing**

<input type="checkbox"/> File Reviews <input type="checkbox"/> Workers Comp IME's <input type="checkbox"/> Permanent Partial Impairment Examination <input type="checkbox"/> MCO Peer Reviews <input type="checkbox"/> Independent Medical Examinations <input type="checkbox"/> Disability Evaluation <input type="checkbox"/> Second Opinion <input type="checkbox"/> Return to work exams	<input type="checkbox"/> Permanent and Total Disability <input type="checkbox"/> Psychological/Psychiatric <input type="checkbox"/> Loss of Use <input type="checkbox"/> Drug Utilization Review <input type="checkbox"/> Short and Long Term Disability <input type="checkbox"/> Functional Capacities Evaluation <input type="checkbox"/> Fitness for Duty <input type="checkbox"/> FMLA
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**IME Experience**

How many years have you performed IME's? \_\_\_\_\_

How many years have you been in practice? \_\_\_\_\_

How many IME's do you perform per month? \_\_\_\_\_

How many depositions have you done? \_\_\_\_\_

What percentage of your IMEs is requested by the employer or their representative? \_\_\_\_\_

What percentage of your IMEs are for Workers compensation issues? \_\_\_\_\_

Disability issues? \_\_\_\_\_

What IME training courses have you completed?

 SEAK  ABIME  ACOEM  Other \_\_\_\_\_

IME Certification:

\_\_\_\_\_

**Diversity Of Practice**

Total percentage of practice related to treatment of injured workers \_\_\_\_\_ %

Total percentage of practice related to Independent Medical Examinations \_\_\_\_\_ %

**Professional Standing, Qualifications, and Requirements**

1. Are you currently licensed and in good standing with your state's licensure board? (i.e., no disciplinary actions initiated or pending) If no, please provide a full explanation and attach it to this application.

 Yes No

2. Has your license to practice in any state been denied, limited, suspended, or revoked? If yes, please provide a full explanation and attach it to this application.

 Yes No

3. Are there any pending or prior medical malpractice lawsuits initiated against you? If yes, please provide a full explanation and attach it to this application.

 Yes No

4. Have you ever been sanctioned or have there been restrictions placed on you by the Federal or State Department of Human Services? If yes, please provide a full explanation and attach it to this application.

 Yes No

5. Have you ever been convicted of any crime other than a non-DUI traffic offense? If yes, please provide a full explanation and attach it to this application.

 Yes No

6. Have you maintained an active clinical practice for the past five years?

 No No**CERTIFICATION**

I, the undersigned, hereby attest that the information given in or attached to this application is accurate and fairly represents the current level of my training, experience, capability, and competence to practice at the level requested. I specifically authorize Northern Ohio Medical Management Corporation to consult with any third party who may have information bearing on the subject matter addressed by this application and to inspect or obtain any reports, records, recommendations, or other documents or disclosures of said third parties that may be material to the questions in this application. I also specifically authorize any such third parties to release said information to Northern Ohio Medical Management Corporation upon request. I hereby release Northern Ohio Medical Management Corporation and any such third parties from any liability for any such reports, records, recommendations, or other documents or disclosures involving me that are made, requested, or received by Northern Ohio Medical Management Corporation to, from, or by any such third parties, including otherwise privileged or confidential information, made or given in good faith relating to the subject matter addressed by this application. By signing this application, I am indicating my willingness to perform Independent Medical Evaluations and maintain qualifications to do so.

Applicant Signature

Date

Please print name