Northern Ohio Medical Management Corporation
P0 Box 452
Sharon Center, Ohio 44274
Telephone: (440 915-3260 or (440) 488-0119
Fax: (866) 878-6543
www.nommc.com 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.
- 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 □ M.D. □ D.O. □ D.C. □ Ph.D. □ D.D.S. □ D.P.M.	
Are you a certified workers compensation provider in your state? □ Yes □ No		Specialty(s):	
Are you currently a panel physician for disability evaluations? □ Yes □ No		Tax I.D. Number:	
Primary Examination Location – 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

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

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	