



MEDICAL DIRECTOR'S OFFICE

Riverview Center
150 Broadway - Suite 195
Menands, NY 12204
1-800-781-2362

PHYSICIAN'S APPLICATION FOR DESIGNATION AS AN IMPARTIAL SPECIALIST

IMPORTANT INSTRUCTIONS TO PHYSICIANS

Designation as an Impartial Specialist is for a five (5) year term.

Complete both sides of this application. All entries are to be typewritten or printed clearly. Return the completed form to the Workers' Compensation Board, Medical Director's Office, Riverview Center, 150 Broadway - Suite 195, Menands, NY 12204. If you have any questions regarding the completion of this form, you may contact us at the above noted address or call 1-800-781-2362.

A physician seeking designation as an Impartial Specialist must be licensed in New York State and not have any license restrictions and/or disciplinary actions in place or pending. The physician must be Board Certified in a medical specialty/subspecialty recognized by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) and must be actively treating patients with a minimum of 5 years of practice in that medical specialty. Please attach a copy of your NYS license, Board certifications and curriculum vitae.

1. Name: First Name Middle Initial Last Name Date of Birth:

2. Medical Degree: MD DO Year Granted:

3. NY Medical License Number: Year License Granted: Registration Expires:

4. Most Recent Board Certification(s): Specialty: Date of Certification: Date Certification Expires:

5. Years of Practice: Specialty: Years Specialty: Years Specialty: Years

6. List your Office Locations in New York State. Attach additional sheet, if necessary. Primary Office Address: Phone Number: Other Office Address: Phone Number:

7. Tax Identification Number:

8. Do you have an active clinical medical practice? Yes No If Yes, how many hours per week are devoted to clinical patient care? If No, have you had an active practice within the last two calendar years? Yes No

9. Are you presently, or were you previously, authorized to: (a) render care under the Workers' Compensation Law? Yes No If Yes, give year and authorization number: (b) conduct independent medical examinations? Yes No If Yes, give year and authorization number:

10. Are you employed by any health provider organization, commercial firm, union or hospital to render care or conduct independent medical examinations? Yes No If Yes, explain here:

11. Do you work in any capacity for insurance carriers, employers or unions? Yes No If Yes, attach a narrative outlining the particulars. Do you have any contract(s) with an IME entity? Yes No
If Yes, attach a narrative outlining the particulars, including the number of independent medical examinations you have performed within the preceding calendar year.
12. Have you completed at least three credits of Continuing Medical Education (CME) courses in the New York State Workers' Compensation Medical Treatment Guidelines or other courses relevant to workers' compensation practice? Yes No
If Yes, attach CME certificate(s) of completion.
If No, please submit CME credit certificate(s) immediately upon completion of the courses. Completion of the CME credit course work is required prior to designation as an Impartial Specialist.
13. (a) Has your name ever been removed (voluntarily or otherwise) from a list of health care providers authorized or designated to render care in any state or under any Federal Program? Yes No
If Yes, provide details: _____

- (b) Has your name been removed (voluntarily or otherwise) from a list of health providers authorized or designated to render care or conduct Independent Medical or Impartial Specialist examinations under the Workers' Compensation Law of any state or under any Federal Program?
 Yes No
If Yes, provide details: _____

- (c) Have you previously been denied authorization to render care or to conduct Independent Medical or Impartial Specialist examinations under the Workers' Compensation Law of any state or under any Federal Program? Yes No
If Yes, provide details: _____

14. (a) Have you ever had a professional license suspended or revoked? Yes No
If Yes, provide details: _____

- (b) Have you ever had restrictions or limitations placed on a professional license? Yes No
If Yes, provide details: _____

15. (a) Have you been or are you currently under investigation by any organization/agency for alleged or actual professional misconduct?
 Yes No
If Yes, provide details: _____

- (b) Have you had or are there any disciplinary actions pending against you at any hospital or organization? Yes No
If Yes, provide details: _____

16. Can you accommodate claimants whose language is other than English? Yes No
If Yes, provide details: _____
17. If your testimony is necessary, on what days of the week are you available to testify?

By application for designation of Impartial Specialist for the New York State Workers' Compensation Board, you agree to abide by the Workers' Compensation Law and specifically agree to perform the examination and submit a report as established by the Chair of the Workers' Compensation Board. You further agree to accept the examination and report fee as determined by the Chair of the Workers' Compensation Board.

The undersigned applicant affirms that the foregoing answers are true to the best of his/her knowledge and belief and agrees that if he/she has made any materially false statement in this application, the Impartial Specialist designation granted as a result of this application may be revoked pursuant to the provisions of the Workers' Compensation Law. The undersigned applicant certifies that he/she does not engage in the splitting of fees with any IME entity in violation of Workers' Compensation Law Section 13-d (2) (g), and Education Law section 6530 (18) and (19).

Signature of Applicant: _____

Date: _____