



Regency Centre
 26016 Detroit Road
 Suite 5
 Westlake, Ohio 44145
 Phone: 440.250.0424
 Fax: 440.250.0429
www.mrgexams.com

IME Physician Panel Application

Instructions:

- Please print or type
- The completed application and support documentation must be signed and returned to MRG at the address above. For any questions, please call (440) 250-0424.
- If there are other physicians in your practice who perform independent medical exams, please ask them to 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)

Applicant 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? 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 (_____) _____
Are you interested in performing <input type="checkbox"/> Workers Comp IMEs <input type="checkbox"/> File Reviews <input type="checkbox"/> Disability Retirement Exams <input type="checkbox"/> FMLA Second Opinion Exams	

IME EXPERIENCE	
How many years have you done IMEs?	How many years have you been in practice?
How many IMEs do you do per Month?	How many depositions have you done?
How many trial testimonies have you given?	
What percentage of your IMEs are 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 taken? <input type="checkbox"/> SEAK <input type="checkbox"/> ABIME <input type="checkbox"/> ACOEM <input type="checkbox"/> Other: _____	IME Certification: _____

DIVERSITY OF PRACTICE	
Total percentage of practice from treatment to injured workers	_____ %
Total percentage of practice related to independent medical exams	_____ %

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.	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Are there any pending or prior medical malpractice lawsuits initiated against you? If yes, please provide a full explanation and attach to this application.	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 to this application.	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 to this application.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you maintained an active clinical practice for the past five years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

REFERENCES

Who may we contact that will speak to their experience with you as an independent medical examiner?	
Company	City, State
Principal Contact Person	Telephone
Services provided <input type="checkbox"/> IMEs <input type="checkbox"/> File Reviews <input type="checkbox"/> Disability Exams <input type="checkbox"/> Other:	
Company	City, State
Principal Contact Person	Telephone
Services provided <input type="checkbox"/> IMEs <input type="checkbox"/> File Reviews <input type="checkbox"/> Disability Exams <input type="checkbox"/> Other:	
Company	City, State
Principal Contact Person	Telephone
Services provided <input type="checkbox"/> IMEs <input type="checkbox"/> File Reviews <input type="checkbox"/> Disability Exams <input type="checkbox"/> Other:	

CERTIFICATION

<p>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 Medical Resource Group 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 Medical Resource Group upon request. I hereby release Medical Resource Group 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 Medical Resource Group 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.</p> <p>By signing this application, I am indicating my willingness to perform independent medical evaluations and maintain qualifications to do so.</p>	
Applicant Signature	Date
Please print name	