

DEPARTMENT OF INDUSTRIAL RELATIONS
INDUSTRIAL MEDICAL COUNCIL
395 Oyster Point Blvd., Ste. 102
South San Francisco, CA 94080
Tel: (650)737-2769 Fax:(650)737-2711

ADDRESS REPLY TO:
P.O. Box 8888
San Francisco, CA 94128-8888



NOTICE OF QME COMPETENCY EXAMINATION March 22, 2003

The Industrial Medical Council (IMC) will administer the next Qualified Medical Evaluator (QME) Competency Examination on **Saturday, March 22, 2003**. Applications for the examination must be submitted to the IMC **postmarked by February 20, 2003**, in order to be accepted for registration. Pursuant to Labor Code §139.2(b)(1), physicians applying for QME status must pass a competency examination.

Physicians who wish to take the exam on March 22, 2003, must submit a completed original Application for Appointment as Qualified Medical Evaluator (IMC Form 100, Rev.7/01) and Registration for QME Competency Examination (IMC Form 102, Rev.7/01). The Application for Appointment as QME must be approved by the IMC before a physician can be registered for the exam. These applications must be postmarked by February 20, 2003, in order to qualify for this exam. Qualified registrants will receive by mail a confirmation letter along with a Candidate Information Booklet. Please keep a copy for your records. The IMC is not responsible for late or lost applications.

If you took the exam since March 18, 2000 and either failed or didn't show for the exam without prior notice, you are required to pay a fee of \$125.00 before being allowed to sit for a subsequent exam. (IMC regulation 11(a)(3)(f)(2))

A physician seeking appointment as a QME on or after January 1, 2001, shall also complete prior to appointment, a course on disability evaluation report writing approved by the IMC. (LC§139.2)

Enclosed are the Application for Appointment as QME (Rev.7/01), Registration for QME Competency Examination (Rev.7/01), a Suggested Reading List and a 12 Hour Report Writing Education Provider List. Also enclosed is an order form for the IMC's *Physician's Guide to Medical Practice in the California Workers' Compensation System*, (Rev. 2001), which is listed in the references and may be purchased from the IMC for \$15.

(NOTE: Only physicians who were registered for the past QME exam on September 21, 2002, and who are retaking the exam in March 2003, may submit their Registration without the Application form since their application is already on file. The IMC may, however, request current status of expired documentation, i.e., expired license, etc.)

You do not need to send any payment at this time. The IMC will assess your annual QME fee after you have successfully passed the QME Competency Exam in order to activate your QME status.

Please call Joanne Van Raam at the IMC at (650) 737-2004 or (800) 794-6900 ext. 2004 for additional application forms or for further assistance.

Thank you. INDUSTRIAL MEDICAL COUNCIL (Enclosures)

September 2002

For Use on the QME Application Form
 IMPORTANT: PLEASE USE THREE LETTER SPECIALTY CODE WHEN
 COMPLETING BLOCK 8 OF APPLICATION FORM

MD/DO SPECIALTY CODES

MAI Allergy and Immunology
 MAA Anesthesiology
 MRS Colon & Rectal Surgery
 MDE Dermatology
 MEM Emergency Medicine
 MFP Family Practice - MD
 OFP Family Practice - DO
 OFM Family Practice - DO - Including Osteopathic
 Manipulation
 MPM General Preventive Medicine
 MOH Hand - Orthopaedic Surgery
 MPH Hand - Plastic Surgery
 MSH Hand - Surgery
 MMM Internal Medicine
 MMV Internal Medicine - Cardiovascular Disease
 MME Internal Medicine - Endocrinology
 Diabetes and 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
 MOQ Medicine - Otherwise Qualified
 MPN Neurology
 MNS Neurological Surgery
 MNM Nuclear Medicine
 MOG Obstetrics and Gynecology
 MPO Occupational Medicine
 MOP Ophthalmology
 MOS Orthopaedic Surgery
 MOB Orthopaedic Surgery - Including Back
 MTO Otolaryngology
 MAP Pain Management - Anesthesiology
 MPP Pain Management - Pain Medicine
 MHA Pathology
 MEP Pediatrics
 MPR Physical Medicine & Rehabilitation
 MPS Plastic Surgery
 MPD Psychiatry
 MRY Radiology
 MSY Surgery
 MSG Surgery - General Vascular
 MTS Thoracic Surgery
 MPT Toxicology - Occupational Medicine
 MET Toxicology - Emergency Medicine
 MUU Urology

NON-MD/DO SPECIALTY CODES

*denotes a doctor of chiropractic who
 has completed a chiropractic post-
 graduate specialty program

ACA Acupuncture
 DCH Chiropractic
 DCN Chiropractic - Neurology*
 DCO Chiropractic - Orthopaedic*
 DCR Chiropractic - Radiology*
 DCS Chiropractic - Sports Medicine*
 DCT Chiropractic - Rehabilitation*
 DEN Dentistry
 OPT Optometry
 POD Podiatry
 PSY Psychology
 PSN Psychology - Clinical Neuropsychology



APPLICATION FOR APPOINTMENT AS QUALIFIED MEDICAL EVALUATOR

For the Department of Industrial Relations
Industrial Medical Council
P. O. Box 8888
San Francisco, CA 94128-8888

FOR IMC USE ONLY
QME NO.:
INPUT DATE:
INPUT BY:

BLOCK 1 (FOR ALL APPLICANTS) 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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

BUSINESS ADDRESS WHERE QME EVALUATIONS WILL TAKE PLACE

<input type="text"/>	CITY	ZIP + 4
<input type="text"/>	<input type="text"/>	<input type="text"/>

MAILING ADDRESS FOR CORRESPONDENCE, IF DIFFERENT

<input type="text"/>	CITY	ZIP + 4
<input type="text"/>	<input type="text"/>	<input type="text"/>

(AREA CODE) PHONE NO.	CAL. PROFESSIONAL LICENSE NUMBER	EXPIRATION (MM/YY)	YEAR ENTERED PRACTICE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

PROCEED TO BLOCK 2

BLOCK 2 (FOR ALL APPLICANTS) IMPORTANT: BLOCK 2 Must be fully completed before proceeding. PROFESSIONAL EDUCATION INDICATE DEGREE OBTAINED (e.g. MD, DC, DO, Ph.D, Psy.D, Ed.D, etc.)

COLLEGE, UNIVERSITY or MEDICAL SCHOOL

<input type="text"/>	If MD or DO, COMPLETE BLOCKS 3,6,7,8,9 If DC, COMPLETE BLOCKS 4,7,8,9,10 If Ph.D, Psy.D or Ed.D, COMPLETE BLOCKS 5,7,8,9 Other Degrees, COMPLETE BLOCKS 7,8,9,10		
CITY	STATE	DATE OF DEGREE	DEGREE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

BLOCK 3 (FOR MDs AND DOs ONLY) POSTGRADUATE TRAINING:

NOTE: For MDs or DOs who are not board certified, state law requires successful completion of a residency training program accredited by the American Council on 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	Location (City/State)	Type	Year From	Year To
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

RESIDENCY: Hospital/Facility	Location (City/State)	Type	From	To
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

RESIDENCY: Hospital/Facility	Location (City/State)	Type	From	To
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

RESIDENCY: Hospital/Facility	Location (City/State)	Type	From	To
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

FELLOWSHIP: Hospital/Facility	Location (City/State)	Type	From	To
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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.

PROCEED TO BLOCK 6 SUBMIT DOCUMENTATION

BLOCK 4 (FOR DCs ONLY)**NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS**

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1) I am certified in California workers compensation evaluation by either a California professional chiropractic association or an accredited California college recognized by the Council. (i.e. IDE Certificate (min. 44 hrs. eff. 4/15/99). | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) I have completed a chiropractic postgraduate specialty program of a minimum of 300 hours taught by a school or college recognized by the council, the Board of Chiropractic Examiners and the Council on Chiropractic Education. | <input type="checkbox"/> | <input type="checkbox"/> |

PROCEED TO BLOCK 7 SUBMIT DOCUMENTATION

BLOCK 5 (FOR Ph.Ds, Psy.Ds AND Ed.Ds ONLY)**NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS**

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1) I am board certified in clinical psychology by the American Board of Professional Psychology, Inc. | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 Industrial Medical Council and have not less than five years postdoctoral experience in the diagnosis and treatment of emotional and mental disorders. | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 and (Agreed Medical Evaluator) AME or 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). | <input type="checkbox"/> | <input type="checkbox"/> |

PROCEED TO BLOCK 7

SUBMIT DOCUMENTATION

BLOCK 6 (FOR MDs AND DOs ONLY)**NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS**

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1) I am board certified in the specialty for which I am applying to become a QME by a board recognized by the Council and the Medical Board of California or the Osteopathic Medical Board of California. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) I completed postgraduate training in the specialty at an institution recognized by the ACGME or the American Osteopathic Association. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) I have qualifications that the Council 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 Board). | <input type="checkbox"/> | <input type="checkbox"/> |

PROCEED TO BLOCK 7

SUBMIT DOCUMENTATION

BLOCK 7 (FOR ALL APPLICANTS)

NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS

TRUE FALSE

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 health care provider-patient relationship which (1) attempts to clinically diagnose and 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.)

PROCEED TO BLOCK 8

BLOCK 8 (FOR ALL APPLICANTS)

PLEASE INDICATE SPECIALTY(IES) FOR WHICH YOU ARE APPLYING TO DO QME EXAMS (USE ENCLOSED SPECIALTY CODE LIST)

Professional practice specialty code:

Professional practice specialty code:

Professional practice specialty code:

Reminder: For MDs & DOs, a copy of your Board Certification or documentation of completion of a training program accredited by the American College of Graduate Medical Education or the American Osteopathic Association must be submitted. For DCs, a certificate from postgraduate specialty diplomate program must be submitted for each specialty.

PROCEED TO BLOCK 9

BLOCK 9 (FOR ALL APPLICANTS, IF COMPLETED)

I have completed a disability evaluation report writing course approved by the IMC.

Course: _____ Date of Course _____

PROCEED TO BLOCK 10

BLOCK 10 (FOR ALL APPLICANTS)

AFFIRMATIONS: Initialling each box affirms that you have read and agree to each of the statements.

INITIAL EACH BOX

License Status

A. My license to practice medicine 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 misdemeanor or felony related to my practice or a crime of moral turpitude.

B. I agree to notify the Industrial Medical Council if my license to practice medicine is placed on suspension, interim suspension, probation or is restricted to notify by my licensing agency. I further agree the Industrial Medical Council if I am convicted of a misdemeanor or felony related to my practice or a crime of moral turpitude. (Do not initial if your statement is untrue, attach an explanation on a separate piece of paper.) I understand that the IMC may deny my application or conditionally accept my application if my license is on probation with my licensing authority.

Financial Interest

C. I agree that I shall abide by all IMC 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 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 IMC.

Cont'd of BLOCK 10 (FOR ALL APPLICANTS)**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. Failure to provide truthful information shall result in denial of applicants appointment and/or disciplinary action. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on (MM/DD/YY) at County CA 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. Please also submit statement of citizenship form.
- 2) All necessary documentation is attached:
 - a) All applicants - A Copy of your current California Professional License.
 - b) MDs, DOs - A copy of your board certification or certificate(s) of completion of a residency training program accredited by the American College of Graduate Medical Education or the American Osteopathic Association. Please provide for all specialties in which you are requesting appointment to perform QME exams.
 - c) DCs - A copy of your certificate in California Workers' Compensation Evaluation or a copy of your certificate from post-graduate specialty diplomate program. For DC specialties other than DCH (e.g. DCR) a copy of your certificate of completion of 300 hours from postgraduate specialty diplomate program is require.
 - d) Ph.D, Psy.D and Ed.D- A copy of your professional diploma(s). Copy of board certification, if appropriate.
 - e) ALL OTHERS - A copy of your professional diploma(s).
 - f) A copy of completion certificate from the report writing course required by Title 8 CCR §11.5, if completed.

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 Industrial Medical Council (IMC) 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 QMEs 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 IMC. It is mandatory to furnish all the appropriate information requested by the IMC. 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 or 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 IMC. An individual may also amend, correct, or dispute information in such personal records (Civil Code § 1798.34-1798.37).

Requests should be sent to:

Industrial Medical Council
P.O. Box 8888
San Francisco, CA 94128-8888
Tel: (650) 737-2700; FAX: (650) 737-2711; E-mail: www.dir.ca.gov

You may request a copy of the IMC 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).

DEPARTMENT OF INDUSTRIAL RELATIONS
INDUSTRIAL MEDICAL COUNCIL
P O Box 8888
San Francisco, CA 94128
Tel: 800-794-6900 or (650) 737-2700 Fax: (650) 737-2711

REGISTRATION FOR
QME COMPETENCY EXAMINATION
MARCH 22, 2003

PLEASE COMPLETE THIS REGISTRATION FORM AND RETURN POSTMARKED NO LATER THAN FEBRUARY 20, 2003.
THE INDUSTRIAL MEDICAL COUNCIL (IMC) IS NOT RESPONSIBLE FOR LATE OR LOST APPLICATIONS. PLEASE SEND
YOUR REGISTRATION AND APPLICATION FORMS TO:

INDUSTRIAL MEDICAL COUNCIL - ATTN: EXAM UNIT

MAILING ADDRESS:
P. O. BOX 8888
SAN FRANCISCO, CA 94128

STREET ADDRESS FOR EXPRESS DELIVERY:
395 OYSTER POINT BLVD., SUITE 102
SOUTH SAN FRANCISCO, CA 94080

NAME: _____ / _____ / _____ / _____
LAST FIRST M.I. JR./SR.

ADDRESS: (street address) _____
(city) _____, CA (ZIP) _____ (+4) _____

PHONE NUMBER.: (____) ____ - _____ FAX NUMBER: (____) ____ - _____

PHYSICIAN'S LICENSE NUMBER: _____ - _____ EMAIL: _____
Prefix Number

EXAM DATE & TIME: **March 22, 2003** **Registration begins at 9:30 a.m.**
Examination begins at approximately 10:00 a.m.

PREFERRED EXAM LOCATION: (TEST SITE WILL BE INDICATED ON YOUR CONFIRMATION LETTER FROM CPS.)
 Northern California Southern California

DO YOU HAVE ANY NEED FOR SPECIAL TESTING ARRANGEMENTS DUE TO A DISABILITY OR RELIGIOUS CONFLICT?

No Yes (Please see the Special Administration Procedures at the back of this page.)

AFFIRMATIONS and 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.

I understand that I must keep my license to practice active and that it currently is active. I certify that I am not currently on probation with my licensing board nor on any court-ordered probation. I certify I will notify the IMC of any of the following events: a) change in my license status; b) any past or future conviction related to the conduct of my practice or for any crime of more turpitude; and c) upon being placed on probation by my licensing board or by any court-ordered probation.

I certify that all the information and supporting documentation which I have previously submitted to the IMC with earlier QME application(s) is bona fide, true and correct.

Executed on: _____ at _____ County & State _____ Applicant's Signature

(OVER)

REGISTERING FOR SPECIAL ADMINISTRATION PROCEDURES

Examinee with a Disabling Condition or Religious Conflict

Special administration arrangements can be provided for examinees who, due to a disability or religious conflict, would not be able to take the test under standard conditions. Requests for special arrangements must be made by the REGULAR REGISTRATION DEADLINE. It may not be possible to honor requests for special testing arrangements received after the regular registration deadline.

Individuals whose religious convictions prohibit them from taking tests on Saturdays or religious holidays may request a special test administration

All of the following must be submitted if special arrangements are needed due to a disability:

- a letter from you describing the condition and the specific special arrangements requested; AND
- a completed registration form.

YOUR PROFESSIONAL LICENSE NUMBER AND TELEPHONE NUMBER MUST APPEAR ON ALL CORRESPONDENCE.

If you need special facilities (e.g., wheelchair accessible building or restrooms), please notify by letter, Cooperative Personnel Services (CPS) at 241 Lathrop Way, Sacramento, CA 95815. In this case, it is not necessary to submit any medical documentation.

Special arrangements for the following conditions can be accommodated at ALL test sites:

- special seating (e.g., due to pregnancy)
- wheelchair accessible facilities
- use of magnifying devices or large-print tests (e.g., for those with visual impairments).

Arrangements that require SUBSTANTIAL CHANGES IN TESTING CONDITIONS may be accommodated only at selected test sites. If it is necessary to relocate you to accommodate any other type of request, you will be contacted directly to discuss the arrangement.

DEPARTMENT OF INDUSTRIAL RELATIONS

INDUSTRIAL MEDICAL COUNCIL

P. O. Box 8888

San Francisco, CA 94128

Tel. No.: (650) 737-2700 or 1-(800) 794-6900 Fax No.: (650) 737-2711



SUGGESTED REFERENCES

(For Physicians planning to take the QME Examination)

Physician's Guide to Medical Practice in the California Workers' Compensation System, An IMC publication, Winter 2001, 3rd edition. (Available from the IMC/Manual Order, P O Box 8888, San Francisco, CA 94128; \$15.00). Also available through the Internet at www.dir.ca.gov/imc/toc.pdf.

Provisions of the California Code of Regulations; Title 8, Industrial Relations, IMC Regulations are part of the study material for the QME examination. You may obtain a copy by calling the IMC at 1-800-794-6900 or 650-737-2767, 2768 or 2769. (A copy is also included with the purchase of The Physician's Guide to Medical Practice listed above).

Herlick, SD. The California Workers' Compensation Handbook (22nd Edition). Dec. 2002 Matthew Bender & Co., Inc.,
(To order: 1-800-223-1940 approximately \$98.00, product #80283-16).

Workers' Compensation Laws of California. 2003 ed. Matthew Bender & Co., Inc.. (To place an order: 1-800-223-1940; approximately \$49.00, product # 840). Especially sections: 139.2, 139.3, 139.31, 4060, 4061, 4062, 4600, 4628. Contains 2002 Labor Code and Provisions of the California Code of Regulations, Title 8, Industrial Relations (IMC Regulations). (Also available through the internet at www.dir.ca.gov , click on left hand side on California Labor Code).

Thurber, P. Evaluation of Industrial Disability, 2nd ed. Oxford University Press, 1960 (Available from UCSF Bookstore, 500 Parnassus Ave., San Francisco, CA 94143. To place an order: 1-800-846-2144; \$12.95).

DEPARTMENT OF INDUSTRIAL RELATIONS

INDUSTRIAL MEDICAL COUNCIL

P. O. Box 8888

San Francisco, CA 94080

Tel. No.: (650) 737-2700 Fax No.: (650) 737-2637



September 2002

**12 HOUR REPORT WRITING
COURSE PROVIDERS**

This letter is to inform you of an important change to the requirements for becoming a Qualified Medical Evaluator, (QME). Effective January 1, 2001, "A physician seeking appointment as a QME on or after January 1, 2001, shall also complete prior to appointment, a 12 hour course on disability evaluation report writing approved by the IMC", (LC§139.2).

The following are the providers approved by the Industrial Medical Council to date:

James Platto-Southern California-209-966-5652

James Platto/Dennis Sosine-Northern California-925-676-9245

Dana Livingstone-Lopez- 760-944-6769

California Chiropractic Association/CSIMS-916-648-2727

Fred Lerner-800-838-8584

Dean Falltrick-530-269-1128

These are the only report writing course providers approved at this time. You must attend a report writing course prior to being appointed as a QME, but are **not** required to take the course prior to the QME examination, unless you wish to.

If you have any further questions I can be reached at 1-800-794-6900, ext. 2004 or directly at 650-737-2004. Thank you for your interest in the Qualified Medical Evaluator program.

Sincerely,
Joanne Van Raam
QME Exam Coordinator
Industrial Medical Council



UPDATED & REVISED

The **Physician's Guide to Medical Practice in the California Workers' Compensation System** (3rd Edition) is now available for order. Many topics in the original version have been updated to California workers' compensation standards through December, 2001.

Published by the Industrial Medical Council, Department of Industrial Relations, State of California.

The Manual will cover:

- an overview of the California worker's compensation system
- the basic concepts of:
 - compensability
 - disability
 - vocational rehabilitation
- the role of treating & evaluating physicians in the workers' compensation system
- the evaluator's conduct & ethics
- guidelines for the evaluator's office staff
- various forms and resource materials

Order your copy today!

(please type or print legibly)

Name: _____

Company Name: _____

Street Address: _____

(No P.O. Box addresses please)

City: _____ State: _____ Zip: _____

Phone Number: _____

Return this order form with a check for \$15.00 payable to "**Industrial Medical Council**" (taxes, shipping & handling included) to:

Industrial Medical Council
Attn: Manual Order
P.O. Box 8888
San Francisco, CA 94128