

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. 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

BUSINESS ADDRESS WHERE QME EVALUATIONS WILL TAKE PLACE (DO NOT USE P. O. BOX)		CITY	ZIP + 4

MAILING ADDRESS FOR CORRESPONDENCE, IF DIFFERENT		CITY	ZIP + 4

(AREA CODE) PHONE NO.	CAL. PROFESSIONAL LICENSE NUMBER	EXPIRATION (MM/YY)	YEAR ENTERED PRACTICE

**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/MEDICAL SCHOOL/TRAINING				<b>If MD or DO, COMPLETE BLOCKS 3,6,7,8,9,10</b> <b>If DC, COMPLETE BLOCKS 4,7,8,9,10</b> <b>If Ph.D, Psy.D or Ed.D, COMPLETE BLOCKS 5,7,8,9,10</b> <b>Other Degrees, COMPLETE BLOCKS 7,8,9,10</b>
CITY	STATE	DATE OF DEGREE	DEGREE	

**BLOCK 3 (FOR MDs AND DOs ONLY)**

**POSTGRADUATE TRAINING/EDUCATION:**

**NOTE:** IF TRAINING WAS RECEIVED FROM A FACILITY/HOSPITAL OUTSIDE THE USA, PLEASE INDICATE BOTH CITY AND COUNTRY IN LOCATION BOX (DO NOT ENTER "SEE RESUME")

PGY 1 or INTERNSHIP: Hospital/Facility	Location (City/State)	Type	Year From	Year To
RESIDENCY: Hospital/Facility	Location (City/State)	Type	From	To
RESIDENCY: Hospital/Facility	Location (City/State)	Type	From	To
RESIDENCY: Hospital/Facility	Location (City/State)	Type	From	To
FELLOWSHIP: Hospital/Facility	Location (City/State)	Type	From	To

**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**

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

- 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).
- 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.

TRUE FALSE

  ***PROCEED TO BLOCK 7*****SUBMIT DOCS.****BLOCK 5 (FOR Ph.Ds, Psy.Ds AND Ed.Ds ONLY)****NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS**

- 1) I am board certified in clinical psychology by the American Board of Professional Psychology, Inc.
- 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.
- 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 an (Agreed Medical Evaluator) AME on 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).

TRUE FALSE

   ***PROCEED TO BLOCK 7*****SUBMIT DOCS.****BLOCK 6 (FOR MDs AND DOs ONLY)****NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS**

- 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.
- 2) I completed postgraduate training in the specialty at an institution recognized by the ACGME or the osteopathic equivalent.
- 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).

TRUE FALSE

   ***PROCEED TO BLOCK 7*****SUBMIT DOCS.****BLOCK 7 (FOR ALL APPLICANTS)****NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS**

- 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.)

TRUE FALSE

  ***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 Board Certification or documentation of completion of a training program accredited by the American College of Graduate Medical Education or the Osteopathic equivalent 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 medical-legal report writing course approved by the IMC.

Course: \_\_\_\_\_ Date: \_\_\_\_\_

**PROCEED TO BLOCK 10**

**BLOCK 10 (FOR ALL APPLICANTS)**

**INITIAL  
EACH BOX**

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

**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 by my licensing agency. I further agree to notify the Industrial Medical Council if I am convicted of a misdemeanor or felony related to my practice or a crime of moral turpitude. 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 certification as a QME by the IMC.

**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: Application for appointment for QME may be returned if it is incomplete or is not submitted with the required supporting documentation. Please make sure that:**

- 1) 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 - Copy of current California Professional License.
  - b) MDs, DOs - copy of board certification or certificate of completion of residency training program accredited by the American College of Graduate Medical Education or the Osteopathic equivalent. Please provide for all specialties in which you are requesting appointment to do QME exams.
  - c) DCs - certificate in California Workers' Compensation Evaluation or copy of certificate from postgraduate specialty diplomate program. For DC specialties other than DCH (e.g. DCR) copy of certificate of completion of 300 hours from postgraduate specialty diplomate program is required
  - d) Ph.Ds, Psy.Ds and Ed.Ds - copy of professional diploma. Copy of board certification, if appropriate.
  - e) ALL OTHERS - copy of professional diploma.
  - f) A copy of completion certificate from the report writing course required by Title 8 CCR §11.5, if completed.

**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

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).