NEW YORK STATE | Workers' Compensation Board

MEDICAL DIRECTOR'S OFFICE
Riverview Center
150 Broadway - Suite 195
Menands, NY 12204
1-800-781-2362

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PHYSICIAN'S APPLICATION FOR RENEWAL OF DESIGNATION AS AN IMPARTIAL SPECIALIST

IMPORTANT INSTRUCTIONS TO PHYSICIANS

You must apply for renewal at least 60 days prior to the end of your current 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 - 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 to renew his/her 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. Home Address: _____
   County: _____ Home Phone Number: (_____) _____

3. NY Medical License Number: _____ Date License Granted: _____ Registration Expires: _____

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

5. Tax Identification Number: _____

6. 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, provide details: _____

7. 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.

8. Are you currently 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: _____

SINCE YOUR APPLICATION OR LAST RENEWAL:

9. Have you maintained 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

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

11. Has your name 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: _____

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

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

13. (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: _____

14. Can you accommodate claimants whose language is other than English? ☐ Yes ☐ No
If Yes, provide details: _____

15. If your testimony is necessary, on what days of the week are you be 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: _____