APPLICATION FOR SPINAL SURGERY 2ND OPINION PHYSICIAN LIST

For the Department of Industrial Relations
Division of Workers' Compensation
P.O. Box 71010
Oakland, CA 94612

FOR OFFICE USE ONLY
NO.:
INPUT DATE:
INPUT BY:

BLOCK 1 (FOR BOTH NEUROSURGEONS & ORTHOPAEDISTS) PLEASE TYPE OR PRINT LEGIBLY

Please list your primary location. DO NOT USE P.O. BOX. You may provide additional office addresses at which you may schedule appointments on a separate sheet.

LAST NAME	FIRST NAME	MI	JR/SR

BUSINESS ADDRESS	CITY	ZIP + 4

MAILING ADDRESS, if different from above	CITY	ZIP + 4

(AREA CODE) PHONE NO.	(AREA CODE) FAX NO.	CAL. PROFESSIONAL LICENSE NUMBER	EXPIRATION (MM/YY)

BLOCK 2 ALL APPLICANTS

MEDICAL SCHOOL

CITY	STATE	DEGREE	YEAR COMPLETED

ALL APPLICANTS are to furnish their board certification and current hospital privileges.

PLEASE LIST:

Hospital/Facility	Location (City/State)	Type	From	To

Hospital/Facility	Location (City/State)	Type	From	To

BLOCK 3 APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS

		YES	NO
1)	I am board certified in neurosurgery by the American Board of Neurological Surgery.	✔	
2)	I am board certified in orthopaedics by the American Board of Orthopaedic Surgery.		
3)	I am board certified in orthopaedics by the American Osteopathic Board of Orthopaedic Surgery.		
4)	I am certified in neurosurgery by the American Osteopathic Board of Orthopaedic of Surgery.		

Date of expiration of board certification:_____

BLOCK 4 ALL APPLICANTS

		YES	NO
1)	Have you ever been formally disciplined by a State Medical Licensing Board? * If the answer is "Yes", please furnish full particulars on a separate sheet.		
2)	Is any accusation by any State medical licensing board currently pending against you? * If the answer is "Yes", please furnish full particulars on a separate sheet.		
3)	Do you currently have hospital privileges in spinal surgery?		
3a)	If the answer is NO, have you had privileges in spinal surgery in the past?		
4)	Have you ever been convicted of a crime? * If the answer is YES, please furnish all particulars on a separate sheet.		
5)	Have you ever applied to the Industrial Medical Council or Administrative Director to be a Qualified Medical Evaluator? * If the answer is NO, please skip to Questions in BLOCK 5.		
6)	If the Answer to Question 5 is YES: Has the Industrial Medical Council or the Administrative Director ever denied appointment for a reason other than for failing to pass the Qualified Medical Evaluator examination, informed you that it would deny appointment for a reason other than for failing to pass the Qualified Medical Evaluator examination, or filed a statement of issues in regard to your application for appointment? * If the answer is YES, please furnish all particulars on a separate sheet.		
7)	If the Answer to Question 5 is YES: Have you ever filed an application or official form with the Industrial Medical Council or Administrative Director which contained an untrue material statement?		
8)	If the Answer to Question 5 is YES: Have you ever been appointed as a Qualified Medical Evaluator?		
9)	If the Answer to Question 8 is YES: Has the Industrial Medical Council or the Administrative Director ever suspended or terminated your appointment as a Qualified Medical Evaluator, placed you on probation, filed an accusation against you, denied reappointment, informed you that it would deny reappointment, or filed a statement of issues in regard to your appointment or reappointment? * If the answer is YES, please furnish all particulars on a separate sheet.		

BLOCK 5 (FOR ALL APPLICANTS)

Most recent hospital privileges in spinal surgery.

Hospital/Facility	Date

BLOCK 6 ALL APPLICANTS

Physicians may not serve in cases in which they have a material professional, familial or financial affiliation with any of the parties or companies involved. YOU are responsible for determining whether you have one of these affiliations in any particular case, and for recusing yourself, although the Administrative Director will attempt to screen out any cases in which a conflict of interest is apparent from the names of the parties involved. So that the Administrative Director can do this screening, please list the names of all companies with which you have a material professional, familial or financial affiliation, as defined in the Regulations.

Workers' Compensation Insurance Companies

1.	3.
2.	4.

Workers' Compensation Third Party Administrators

1.	3.
2.	4.

Utilization Review Companies

1.	3.
2.	4.

Group Health Plans

1.	3.
2.	4.

Medical Group(s). (Please include the address(es) of the group)

1.	3.
2.	4.

Independent Practice Association(s). (Please include the address(es) of the association)

1.	3.
2.	4.

Hospital or Ambulatory Surgery Centers. (Please include the address(es) of the facility)

1.	3.
2.	4.

Spinal Surgery Related Drugs, Devices, Procedures or Therapies.

1.	3.
2.	4.

PROVIDE ADDITIONAL SHEETS WHEN NECESSARY

BLOCK 7 ALL APPLICANTS - PLEASE CHECK:

1) That your application is fully completed, dated and signed with an original signature.
We will not accept faxed applications.

2) That all necessary documentation is attached:
- ❖ A copy of your current California Professional License.
- ❖ A copy of your board certification(s).
- ❖ Certification of your current hospital privileges.

IMPORTANT: Your application for appointment as a Second Opinion Surgeon shall be returned if it is incomplete, and it must be submitted prior to obtaining your appointment.

BLOCK 8 ALL APPLICANTS

License Status

A. My license to practice medicine is active and is neither restricted nor encumbered by suspension, interim suspension or probation.

B. I agree to notify the Administrative Director if my license to practice medicine is placed on suspension, interim suspension, probation or is restricted by my licensing agency, or if any State Medical Licensing Board files an accusation against me.

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.

Executed on _____ **at** _____**, CA** _____
(MM/DD/YY) **County** **Applicant's Signature**

A PUBLIC DOCUMENT

PRIVACY NOTICE - The Information Practices Act of 1977 and the Federal Privacy Act require the Administrative Director 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 Administrative Director. It is mandatory to furnish all the appropriate information requested by the Administrative Director. 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 Administrative Director. An individual may also amend, correct, or dispute information in such personal records (Civil Code § 1798.34-1798.37).

Requests should be sent to:

Division of Workers' Compensation-Medical Unit
P.O. Box 71010
Oakland, CA 94612
(510) 286-3700 or (800) 794-6900
Fax: (510) 622-3467

You may request a copy of the Division of Workers' Compensation 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).