STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

APPLICATION FOR INDEPENDENT MEDICAL EXAMINERS

1. Name:_____

   Professional title: MD☐ DO☐ PhD☐ DC☐ DDS☐ Other:_____

2. Street Address:_____

   City: _____ State: _____ Zip: _____

   Phone: _____ Fax: _____

   Email Address:_____

3. List the specialties which you are applying to provide Independent Medical Examinations (IMEs) for:

   A. How many ***full*** years have you practiced the above: _____

4. Do you currently hold ABMS, AOBMS, ACA board certification in the specialty listed in #3:

   Yes☐ No☐ There is no certification board in that specialty ☐

5. Do you hold board certification in any other specialty? Yes☐ No☐

   A. If yes, please list the other specialty and the years of practice in that field:

6. Have you successfully completed formal training in performance of IMEs and/or impairment evaluations through the International Academy of Independent Medical Examiners (IAIME) [also known as National Association of Disability Evaluating Professionals (ADEP)] or a similar organization? Yes ☐ No ☐

   A. If yes, please list the name of the training organization and date of completion:

7. How many IMEs relating to workers' compensation cases have you performed within the past two (2) years? _____

8. Please indicate the state(s) in which you have conducted IMEs?

9. According to the New Mexico Workers' Compensation Act 52-1-24 NMSA 1978 A, impairment is "based upon the most recent edition of the American Medical Association's (AMA) Guide (the Guides) to the Evaluation of Permanent Impairment."
   What edition(s) of the American Medical Association (AMA) Guides have you used for evaluating impairment?

ATTESTATION

As a requirement for consideration of my application for inclusion on the LIST OF APPROVED INDEPENDENT MEDICAL EXAMINERS FOR WORKERS' COMPENSATION (LIST).

I attest that I meet the following criteria and agree to the following provisions:

1. I currently hold a medical license to practice as: MD ☐ DO ☐ PhD ☐ DC ☐ DDS ☐
   Title:_____ License #:_____Expiration Date:_____
   State(s) licensed to practice in:_____

2. My medical license is active and current, and has not been suspended or revoked.
3. I agree to provide IMEs, as my schedule permits, in accordance with the most current New Mexico Workers' Compensation Act and when appropriate, the New Mexico Health Care Provider (HCP) Fee Schedule
4. I agree to comply with the IME Provider Selection Committee's policies regarding criteria for inclusion on the LIST, and agree that it is my responsibility to notify the IME Provider Selection Committee of any change of information within 30 days of the change. My failure to notify the Committee may result in my removal from the LIST.
5. I agree to provide a list of references if required by this application, and to authorize the IME Provider Selection Committee to contact the references listed.
   I authorize those references to provide information regarding my ability to perform objective, non-biased IMEs and the quality of my IME services.
6. I am proficient in the most current guidelines appropriate to my specialty, (e.g., AMA, DSM, etc.) in performing medical impairment ratings and determinations of residual/functional capacity. I agree to base such evaluations on these guidelines as required by the current New Mexico Workers' Compensation Act.
7. As a requirement for inclusion on the LIST:
   Semi-annually I agree to disclose (in the space provided below), any formal or informal agreements or arrangements pertaining to medical services with employers, insurance carriers, third party administrators, attorneys, other health care providers, labor organizations, public officials or other organizations.

I HAVE THE FOLLOWING AGREEMENT(S) AND/OR ARRANGEMENT(S) PERTAINING TO MEDICAL SERVICES PROVIDED WITH THE INDIVIDUAL(S) AND/OR ORGANIZATIONS LISTED BELOW:

☐ None

8. As a condition to perform an IME assigned by a WCA Judge:
   I agree to complete and attach an approved WCA form to each Independent Medical Examiner's formal report, attesting no formal or informal agreements, or arrangements with employers, insurance carriers, third party administrators, attorneys, other health care providers, labor organizations, public officials, or other organizations which may interfere or potentially interfere, as a conflict of interest, with my objectives and unbiased performance of the specific IME being performed under the New Mexico Workers' Compensation Act.

9. I agree to abide by the present and future New Mexico statutes, HCP fee schedules, rules and regulations relating to health care services for New Mexico workers' compensations claims.

10. Attached are all applicable documents required to be considered:
    a. Current CV/ Resume
    b. Copy of your current medical license
    c. Board Certification Credentials
    d. Formal Training Credentials
    e. Three (3) samples of IMEs that you preformed within the last two (2) years.

_____	_____	_____
Print Name	Signature	Date

FOR CONSIDERATION OF YOUR APPLICATION, ALL DOCUMENTS LISTED IN #10 MUST BE ATTACHED. FAILURE TO DO SO WILL RESULT IN DELAY IN THE PROCESSING OF THE APPLICATION

Workers' Compensation Administration
Medical Cost Containment Bureau
Attn: IME Provider Selection Committee
PO Box 27198
Albuquerque, NM 87125-7198
Email: WCA-MCC@state.nm.us
Phone: 505-841-6042
Fax: 505-841-6078

Email this Application