Clear Entire Form

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION
633 17th St., Suite 400, Denver, CO 80202-3626
303.318.8655

Request for Appointment to the Division Independent Medical Examination Panel (DIME)

Please Print or Type	Date of Application: _____/_____/_____

Personal Identification

Last Name:	First Name:	MI:
Office Address:	City: State:	Zip:
Colorado Professional License No.:	Office Phone: ( )	Fax: ( )
Degree:	Specialty:	

If you are a medical doctor or a doctor of osteopathy, complete the following:

Currently Board Certified by the American Board of Medical Specialties or the American Osteopathic Association?
☐ Yes ☐ No Date: / /

Currently Board Eligible for specialty certification by the American Board of Medical Specialties or the American Osteopathic Association?: ☐ Yes ☐ No

If yes, Board certified or eligible, name of Board:

Documentation of Board Certification or eligibility in field of specialty must accompany this application.

Do you intend to do impairment ratings? ☐ Yes ☐ No
If yes, Level II Accreditation is necessary.

Have you had more than 384 hours of direct patient care (excluding medical/legal evaluation) as part of your practice within the last calendar year **OR** engaged in at least 384 hours of direct patient care (excluding medical/legal evaluation) during the previous five years **and** demonstrated additional competency in the field of disability evaluation through certification by the American Board of Independent Medical Examiners, the International Academy of Independent Medical Evaluators, or equivalent continuing medical education courses?

☐ Yes ☐ No

I certify that as of the date of this application my Colorado medical license is active, with no limitations or restrictions. I will notify the DIME Unit and withdraw from the DIME panel should any restrictions be imposed.

☐ Yes ☐ No

CERTIFICATION

I request approval as an independent medical examiner. I will provide independent and objective medical decisions in all cases that come before me. I will decline a request to conduct an independent medical examination if I have a conflict of interest for any reason. I agree to conduct a Division Independent Medical Examination between 45 and 75 calendar days from request.

I agree to submit a report to the Division and both parties as marked on the DIME Application within 20 calendar days of the examination of the claimant. This report will include the DIME Examiners Worksheet, my written report, and the applicable AMA Guides worksheets. I understand my performance will be measured by the quality of my examination and reports, and not by whether my recommendations are perceived as favorable or unfavorable to the parties involved.

I have read and understand all of Rule 11, which describes the Division Independent Medical Examination program.

I accept that examinations performed for the Division of Workers' Compensation are paid according to fees set by the Division of Workers' Compensation.

_____ _____/_____/_____

Signature Date

Subscribed before me this _____ day of _____, _____.

_____ SEAL

Notary Public

Address:

My Commission Expires: _____