

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT  
 Division of Workers' Compensation  
 Independent Medical Examination Section  
 633 17<sup>th</sup> St., Suite 400, Denver, CO 80202-3626  
 303.318.8655

**Request for Appointment to the  
 Independent Medical Examination Panel**

*Please Print or Type*

Date of Application: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Personal Identification**

Last Name:

First Name:

MI:

Office Address:

City:

Zip:

State:

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) as part of your practice within the last year?

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 IME unit and withdraw from the IME panel should any restrictions be imposed.

Yes

No

Please send all applications to the attention of the IME coordinator at the above address

(see reverse side)

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 serve on the panel for a minimum of two years and to conduct an independent medical examination between 35 and 50 calendar days from request.

I agree to submit a report to the Division and both parties as marked on the IME Application, according to Division guidelines, within 20 calendar days of the examination of the claimant. This report will include the Division IME 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 independent medical exam 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 \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

SEAL

Address:

My Commission Expires: \_\_\_\_\_