CHECK ONE:	CHECK ONE:
❑ Physician ❑ Podiatrist ❑ Chiropractor ❑ Psychologist	❑ Initial Authorization ❑ Reinstatement ❑ Change in Rating (Physician only)

State of New York
WORKERS' COMPENSATION BOARD
Office of Health Provider Administration
100 Broadway-Menands
Albany, NY 12241
1-800-781-2362

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

HEALTH PROVIDER'S APPLICATION FOR AUTHORIZATION UNDER THE WORKERS' COMPENSATION LAW

IMPORTANT INSTRUCTIONS TO HEALTH PROVIDERS

Complete both sides of this application. Do not fill in shaded area. All entries are to be typewritten or printed clearly. Illegible applications will be returned to the applicant.
Physicians: Submit in duplicate to your County Medical Society. Osteopathic physicians may submit to their County Medical Society or the New York State Osteopathic Medical Society. A copy of the application (face sheet only) must be filed with the Workers' Compensation Board at the above address at the same time it is submitted to the Medical Society.
Other Health Providers: Submit to appropriate committee (Podiatry Practice Committee, Psychology Practice Committee, or Chiropractic Practice Committee) at the above address.

The undersigned hereby makes application to be authorized by the Chair, Workers' Compensation Board for the following: CHECK ALL THAT APPLY

☐ To render appropriate care to persons suffering injury or illness in accordance with the Workers' Compensation Law (WCL), to volunteer firefighters in accordance with the Volunteer Firefighters' Benefit Law (VFBL) and volunteer ambulance workers in accordance with the Volunteer Ambulance Workers' Benefit Law (VAWBL), and requests the following rating (physicians only)_____ .

☐ To conduct independent medical examinations (IME's) of persons suffering work-related injury or illness under the WCL, VFBL and VAWBL.

1. Name_____ Date of Birth_____

2. Home Address_____

   County_____ Home Telephone Number_____

3. New York State Professional License Number_____ Date License Granted_____

4. Office Address(es): List below all of your offices of practice in New York State. Attach an additional sheet of paper if necessary. For each address listed below, you must have a valid registration certificate from the New York State Education Department. If any of your office addresses are not currently registered, please call the Division of Professional Licensing Services at (518) 474-3817. Be advised that any address registered with the Education Department will be given out to claimants.

   Principal Office Address_____ Office Tel. No._____
   Street City County Zip Code

   Other Office Address_____Office Tel. No. _____
   Street City County Zip Code

5. **Major Hospital Affiliations in New York State:**

   A. Hospital_____ Zip Code_____

   Clinical Service_____ Positions Held_____Date_____

   B. Hospital_____ Zip Code_____

   Clinical Service_____ Positions Held_____Date_____

6. Current Professional Society Memberships:
   - ❑ American Medical Association
   - ❑ Medical Society of the State of New York
   - ❑ New York State Osteopathic Medical Society
   - ❑ County Medical Society: County of _____
   - ❑ Specialty Societies _____
   - ❑ Board Certification, American Board of Medical Specialties
   - ❑ Board Certification, American Osteopathic Association
   - ❑ Board Certification, Other _____

   Physicians seeking authorization to conduct Independent Medical Examinations (IME's) must be board certified by a medical or osteopathic specialty board that is recognized by the Workers' Compensation Board.

7. Graduate of (Professional School) _____Degree _____ Year _____

8. Post-graduate study in College or Hospital_____

9. All psychologists, podiatrists, chiropractors, please attach curriculum vitae including academic training, supervision and experience.

10. Have you completed an authorized or approved residency? ❑ Yes ❑ No If "yes," attach a copy of the certificate of completion or a letter from a hospital administrator confirming completion of approved residency.

11. If you have been certified by any specialty board, specify board and date of certification below and attach proof of certification:

    a. _____ Date_____ b. _____ Date_____

For Office Use Only - Do Not Fill in Shaded Area

Status **a.** **b.** **Date of Current Rating** **1** **2** **3** **4** **Rating(s) Given** **By:** **Med. Reg. Sec.**

12. 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," explain_____

_____

13. Are you presently, or were you previously, authorized to (a) render care under the Workers' Compensation Law? ❑ Yes ❑ No If "Yes", give date and authorization number:_____ (b) conduct independent medical examinations? ❑ Yes ❑ No If "Yes", give date and authorization number:_____

14. Have you ever previously applied for authorization to render care or conduct independent medical examinations under the Workers' Compensation Law, which application was not granted? ❑ Yes ❑ No

15. Was your name ever removed (voluntarily or otherwise) from a list of health providers authorized to render care or conduct independent medical examinations under the Workers' Compensation Law of any state or under any Federal program? ❑ Yes ❑ No If "Yes," give state or program involved and explain reason for removal:_____

_____

If your authorization was reinstated, give date of reinstatement _____

16. Have you ever had a professional license suspended or revoked? ❑ Yes ❑ No If "Yes," give state or jurisdiction and explain reason:_____

_____

17. Have you ever had restrictions or limitations placed on a professional license? ❑ Yes ❑ No If "Yes," give state or jurisdiction and explain reason:___

_____

18. Can you accommodate claimants whose language is other than English? ❑ Yes ❑ No If "Yes," please specify: _____

The applicant acknowledges that any authorization granted by the Chair is conditioned upon compliance with the Workers' Compensation Law and Board Rules, including but not limited to the following:

- The applicant shall submit all records and evidence needed for any investigation upon direction by the Chair, Workers' Compensation Board or the local County Medical Society, or the New York State Osteopathic Medical Society, or the appropriate Practice Committee.
- The applicant shall file timely, complete and accurate reports of treatment rendered to claimants, as required by law or regulation or directed by the Chair or the Board, whenever applicant renders such treatment. Such reports of treatment shall be timely filed as required by the Chair or Board, and shall be provided upon request to the employer or employer's insurance carrier. The applicant shall transmit copies of medical reports to claimant's licensed representative or attorney upon receipt of a written request or consent signed by the claimant and accompanied by a notice of retainer, where applicant is acting as claimant's attending physician or medical consultant.
- The applicant shall submit a signed, certified copy of each report of an independent medical examination on the same day and in the same manner to the Board, the insurance carrier, the claimant's attending physician or other attending practitioner, the claimant's representative and the claimant. If authorized to conduct independent medical examinations, the applicant further agrees to provide such reports and submit to such investigation as may be required by the Chair.
- The applicant shall not undertake or continue the care, or conduct an independent medical examination, of a claimant whose condition requires a professional service for which he/she is not qualified and authorized by the Chair, Workers' Compensation Board, or which is outside the limits prescribed by the New York State Education Law for podiatrists, chiropractors, or psychologists, as the case may be. In the event that a case develops a complication beyond applicant's qualification and authorization, applicant shall promptly refer such case for consultation and/or to the service of a health provider qualified and authorized to render the needed care or conduct the independent medical examination.
- The applicant shall appear before the Board or answer upon request of the Chair, the Board, a Workers' Compensation Law Judge, the appropriate Practice Committee (if applicable), or any duly authorized officer of the State, any questions in connection with a workers' compensation, volunteer firefighter or volunteer ambulance worker claim.
- The applicant shall refrain from treating subsequently for remuneration, as a private patient, any person seeking medical treatment or submitting to an independent medical examination in connection with, or as a result of, any injury covered under the Workers' Compensation Law, the Volunteer Firefighters' Benefit Law, or the Volunteer Ambulance Workers' Benefit Law, if he/she has been removed from the list of health providers authorized to render such medical care or to conduct such independent medical examination or if the person seeking treatment has been transferred from his/her care in accordance with the law.
- The applicant further shall abide by the provisions of the Workers' Compensation Law and the Rules adopted thereunder.

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, any authorization granted as a result of this application may be revoked pursuant to the provisions of the Workers' Compensation Law.

Signature of Applicant_____ Date_____

☐ APPLICATION RECOMMENDED: ☐ Treatment - Rating Recommended_____ ☐ IME
Physicians only
☐ APPLICATION NOT RECOMMENDED

By: ❑ Medical Society of the County of _____ ❑ New York State Osteopathic Medical Society
❑ Podiatry Practice Committee ❑ Chiropractic Practice Committee ❑ Psychology Practice Committee

Medical Society
or Practice Committee Chair_____ _____ _____
Typed or Printed Name Signature Date

Practice Committee Member_____ _____ _____
Typed or Printed Name Signature Date

Practice Committee Member_____ _____ _____
Typed or Printed Name Signature Date