



# Independent Medical Examiner Application For Appointment

Nebraska Workers' Compensation Court  
P. O. Box 98908  
Lincoln, NE 68509-8908

402-471-6468 or 800-599-5155  
402-471-2700 (FAX)  
<http://www.wcc.ne.gov/>

Applicant's Name:		Social Security Number:	Date of Birth:
Address:		City or Town:	
State:	Zip Code:	Business Telephone:	

## EDUCATION AND TRAINING

Name & Location	Dates From/To	Major	Degree	Month/Year of Degree
College/University:				
Medical School:				
Osteopathic School:				
Chiropractic School:				
Other:				

## PROFESSION

Specialty:	Subspecialty:
Board certification with:	Board certification with:
Certification expires: _____	Certification expires: _____
Have you ever performed an independent medical exam? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how many years have you been performing IMEs? _____	
What percentage of current practice is IMEs?	
List any IME training you have attended:	
Please list any experience or education concerning workers' compensation principles or the Nebraska workers' compensation system:	
Please identify any employer, insurer, attorney, employee group, managed care plan or representatives of any of these to whom you are under contract or who regularly use your services:	
If appointed, what type of cases would you prefer be referred to you?	

# Independent Medical Examiner — Application For Appointment

Nebraska State License # _____	Tax I.D. # _____	Drug Enforcement Agency # _____
Are you currently licensed in any other state? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please list state and license #: _____		
List any other registrations, certifications or licenses you possess: _____		

Have you ever been subject to disciplinary action? Yes  No  If yes, please explain: \_\_\_\_\_

Have you ever voluntarily surrendered your license? Yes  No  If yes, please explain: \_\_\_\_\_

## PRACTICE HISTORY

**Present practice name and location:**

Name: \_\_\_\_\_ Type of Practice: \_\_\_\_\_ From: \_\_\_\_\_

Address: \_\_\_\_\_

List other site addresses if applicable: \_\_\_\_\_

**Prior practice name(s) and location(s):**

1. Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

City, State & Postal Code: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

2. Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

City, State & Postal Code: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

3. Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

City, State & Postal Code: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

I request appointment to the list of independent medical examiners maintained by the Nebraska Workers' Compensation Court. I will provide independent, impartial and objective medical findings in all cases that come before me. I will decline a request to serve as an independent medical examiner only for good cause shown. If I determine an examination is necessary, I will contact the employee within 10 business days after receipt of records from all parties to schedule an appointment. I will submit a written report within 10 business days following receipt of all necessary records and information, the completion of an examination, or the completion of any required tests, whichever is applicable. I will accept the fees established pursuant to Rule 65 as payment in full for services rendered as an independent medical examiner. I will submit to a review pursuant to Rule 62, E.

I have read and understand Rule 62 though Rule 66 of the Nebraska Workers' Compensation Court, which describe the independent medical examiner system. I agree to comply with all of the provisions of these rules.

I hereby attest that the information contained in this application is correct to the best of my knowledge and belief. I understand that false or misleading information may result in the rejection of my application or in my removal from the list if I am appointed.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE