

Metro Medical Services: PROVIDER PANEL APPLICATION

Name: _____
Phone: _____ Email: _____
License #: _____ State: _____ Since: _____ Exp.: _____
NY Workers' Comp # (only for NY applicants): _____
Medicaid #: _____ Tax ID #: _____
SS# _____
Language(s) spoken & written: _____
Office Address: _____ FAX: _____
City: _____ State: _____ County: _____ Zip: _____

Additional Office Address; Where IME would take place
1) _____ 2) _____

Office Hours: _____ Office Hours: _____

Name of person to contact to schedule appointments: _____

Medical/Dental School: _____ Location: _____
Year/Degree: _____ Internship Hosp: _____ Yr: _____
Residency Hosp: _____ Yr: _____ Fellowship: _____ Yr: _____

Are you BOARD CERTIFIED: YES NO (circle one)
Certificate # _____ Date of Certificate: _____
Since _____ Specialty(s): _____ Specialty(s): _____

- *Do you have medical malpractice insurance coverage? YES NO
- *Is your license in New York or any other state currently under investigation? YES NO
- *Has your narcotics license in New York or any other state ever been revoked, suspended or relinquished to avoid such action? YES NO
- *Have your privileges at any hospital ever been limited, revoked or suspended? YES NO
- *Has your membership in the medical staff of any hospital ever been revoked or voluntarily surrendered to avoid such action? YES NO
- *Has your membership in any professional society ever been revoked or voluntarily surrendered to avoid such action? YES NO
- *Have you ever been censored or reprimanded by a professional society? YES NO
- *Have you ever been convicted of a felony misdemeanor? YES NO
- *Have there been any sexual misconduct charges brought against you? YES NO
- *Have you ever been the defendant in a malpractice case? YES NO

Provide Details (attach additional sheets, if necessary):

November 2002

What percentage of your practice is devoted to consulting work vs. private practice?

Current hospital affiliations: _____

Fill in your fee schedule for:

IME's _____ Peer Review _____

(Please note: Doctor is not paid for missed appointments)

What is the approximate time it would take to perform your typical IME:

What are the counties that you would be willing to testify in ? (Metro NY only)

What is your availability for testifying purposes? How much advance notice do you need to clear your calendar?

Are you willing to meet personally with counsel to go over possible areas of your testimony?

What is your charge for testifying for a half-day, full day, etc.? When do you require your testimony fee to be paid?

What is your charge for a cancelled testimony request?

No Charge _____ or Other (please specify): _____

Have you ever experienced a problem with State Farm Insurance and/or it's counsel? If so, what is the nature of that problem?

If you need additional space to clarify any of your answers please attach a separate sheet. Thank you.

ATTESTATION AND RELEASE

I certify that the above information is true and complete and authorize Metro Medical Services to make inquiry of any parties named in this application to verify the information supplied. Metro Medical Services and all parties providing information shall be immune from liability for such inquiry or responses.

SIGNATURE

DATE

FOR OFFICE USE ONLY