STATE OF MAINE
WORKERS' COMPENSATION BOARD
OFFICE OF MEDICAL/REHABILITATION SERVICES
27 STATE HOUSE STATION
AUGUSTA, ME 04333-0027

JANET T. MILLS
GOVERNOR

JOHN C. ROHDE
EXECUTIVE DIRECTOR/CHAIR

Application for Section 312 Independent Medical Examiner Program

Applicant Name:	License Number:
Specialty:	Subspecialty:

1. Education, Training and Work History: ATTACH UPDATED CURRICULUM VITAE

2. Are you Board certified? Yes ☐ No ☐

   If yes, please list board certifications:______________________________

   ____

3. Do you currently have an active, treating practice? Yes ☐ No ☐

   Per Board rules, "active, treating practice means the provider has direct involvement in evaluation, diagnosis and treatment of patients on a frequent and regular basis in their specific field of expertise".

   If yes, what percentage of professional time and hours per average week is in the treatment of work-related injuries/illnesses? ______%

   If no, did you have an active, treating practice within the last 24 months? Yes ☐ No ☐

   If your answer to the above is yes, what is the last date you had direct involvement in evaluation, diagnosis and treatment of patients on a frequent and regular basis? ______________________

4. Do you perform medical evaluations under the Maine Workers' Compensation Act §207?
   Yes ☐ Number of §207 exams performed in the last calendar year? ______ No ☐

5. Do you have any potential conflicts of interest? Yes ☐ No ☐
   Potential conflicts of interest may result from a relationship(s) with industry, insurance companies, and labor groups. For example, a potential conflict of interest exists when you or someone in your immediate family receives something of value from one of these groups in the form of an equity position, royalties, consultantship, funding by a research grant, or payment for some other service.

   If your answer to the above is yes, please describe in detail (use additional sheets if necessary):

   ____

   ____

TEL: 207-287-7062 FAX: 207-287-7198

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Application for Section 312 Independent Medical Examiner Program - continued

I hereby attest that the information contained in this application is correct to the best of my knowledge and belief and understand that any false, misleading or incomplete information may result in the rejection of my application or result in my dismissal from service if I am selected.

____ ________________________________

Sign Date

____

Print Name

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