

Rhode Island Workers' Compensation Court  
Impartial Medical Examiner or  
Health Care Review Team Participant

Application/Renewal

Please complete, sign, and return with CURRENT CURRICULUM VITAE to Medical Advisory Board, Workers' Compensation Court, One Dorrance Plaza, Providence, R.I. 02903.

APPLICATIONS NOT FULLY COMPLETED WILL BE RETURNED!!!

Please Type or Print: Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_

1. Degree: \_\_\_\_\_ 2. Board of Registration Number: \_\_\_\_\_
3. Current practice status: Active \_\_\_\_\_ Inactive \_\_\_\_\_
4. Malpractice insurance current: Yes \_\_\_\_\_ No \_\_\_\_\_ Insurer: \_\_\_\_\_  
Amount of Insurance \_\_\_\_\_
5. Board Certification? Yes \_\_\_\_\_ No \_\_\_\_\_ OR Board Qualified? Yes \_\_\_\_\_ No \_\_\_\_\_
6. Primary Specialty: \_\_\_\_\_
7. Current staff appointment at accredited organization? Yes \_\_\_\_\_ No \_\_\_\_\_  
List Organization(s): \_\_\_\_\_
8. Have you evaluated workers' compensation claimants as an IME during the past 12 months?  
Yes \_\_\_\_\_ No \_\_\_\_\_
9. Indicate any disciplinary/malpractice actions, past or present, filed against you. Attach separate sheet if necessary.  
\_\_\_\_\_  
\_\_\_\_\_
10. Have you ever been convicted of a felony? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
11. Are you under contract with or regularly employed or regularly retained by a compensation insurer or self-insured employer? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please list the insurer(s) or self-insured employer(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date