Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002
800-332-2667

PHYSICIAN APPLICATION FOR APPOINTMENT TO THE CERTIFIED PHYSICIAN PROGRAM (CPP) AND/OR MEDICAL IMPAIRMENT RATING (MIR) REGISTRIES

Name_____ MD☐ DO☐ DC☐
Check one

License # _____ Group/Practice d/b/a _____

Mailing Address _____ Phone #_____ ext _____
Please provide actual office street address(es) on a separate sheet

City_____ State_____ Zip_____

Applying for appointment to: CPP Registry ☐ MIR Registry☐ Both CPP and MIR Registries☐

Have you had charges/actions on your license to practice in any state or country? NO ○ YES ○

If yes, please attach a copy of the charges or actions.

Have you been charged with a felony or other criminal activity or gross misdemeanor? NO ○ YES ○

If yes, please give details on a separate sheet.

Do you have hospital privileges? NO ○ YES ○ Please name all hospital(s) and city(ies). _____

_____

Have your hospital privileges in any state or country ever been modified or withdrawn? NO ○ YES ○ If yes, please give details on a separate sheet.

List your specialty areas: _____

_____

List all chapters of the **AMA Guides, Sixth Edition** for which you have received training and for which you wish to receive MIR referrals_____(Please provide proof of training).

Please provide the office address(es) for each location that you will use to perform evaluations. Use additional sheets if necessary.

Group/Practice d/b/a _____

Office Street Address 1_____

City_____ State_____ Zip_____

Office Contact _____ E-Mail_____ Fax#_____

Group/Practice d/b/a _____

Office Street Address 1_____

City_____ State_____ Zip_____

Office Contact _____ E-Mail_____ Fax#_____

Are you certified or accredited by any organization to perform disability, impairment evaluation and ratings?
NO ◯ YES ◯ Name of the organization:_____ Date certified:_____
Please submit proof with the application.

Approximate number of impairment ratings you have performed in the last 24 months. _____

I request appointment to the Certified Physician Program (CPP) and/or Medical Impairment Rating (MIR) Registry. I understand that it is the expectation of the Tennessee Bureau of Workers' Compensation that all workers will be treated with dignity and respect.

If appointed to the CPP Registry, I agree to treat and evaluate workers' compensation patients in a timely manner, to follow the Bureau's Best Practices for Treating and Evaluating Injured Workers, and to abide by the CPP Program rules. I understand that my certification is for three years and must be renewed if I wish to remain certified.

If acting as an MIR Physician, **I will provide independent, objective, and timely impairment ratings in all cases that come before me**. I understand my performance will be measured by the quality, accuracy and timeliness of my evaluations and reports and by my willingness and availability to perform MIR evaluations and not by whether my recommendations are perceived as favorable or unfavorable to the parties involved. I also understand that I am not guaranteed referrals. I will not base my findings on the absence or presence of an attorney in the case or on the potential size of an award. If I am offered financial awards to influence my decision, I will immediately report the situation to the Administrator's office of the Bureau. I realize that MIR evaluations performed for the Bureau are paid according to a published fee schedule. I certify that I have received training in the chapters of the ***AMA Guides to the Evaluation of Permanent Impairment*** for which I have requested referrals on this application. I will adequately conduct impairment evaluations and assign appropriate impairment ratings

I understand that only fully qualified physicians, as determined solely by the Administrator of the Bureau or his/her designee, will be approved for appointment to the CPP and MIR Registries.

I have provided complete and accurate information on this application. I will immediately notify the Bureau and provide a copy of the charges or final order should any of the following situations occur:

1. Any temporary or permanent probation, suspension, revocation, or limitation is placed on my license to practice by any court, board, or administrative agency;
2. I am charged with any crime, gross misdemeanor, felony, or violation of statutes or rules by any administrative agency, court, or board;
3. I am convicted of any crime, gross misdemeanor, felony or violation of statutes or rules by any administrative agency, court, or board.
4. Any event reportable to the National Practitioner Database.

I understand that:

- **It is my responsibility to inform the Bureau of Workers' Compensation in writing if there is any change in the status of my practice or license and of any current or completed action of any nature.**
- **The privilege of continuing as a Certified and/or MIR physician is not guaranteed.**
- **If approved, I may be removed from these registries at any time based on the following factors including, but not limited to:**
    - **A misrepresentation on the "Application for Appointment to the Certified Physician Program (CPP) and Medical Impairment Rating (MIR) Registry"**
    - **Failure to report prior involvement or conflict of interest in an MIR case assignment**
    - **Refusal and/or substantial failure to comply with the applicable provisions of the CPP and MIR Program Rules of procedure including repeated failure to determine impairment ratings correctly using the *AMA Guides*, as determined by the Medical Director**
    - **Inability to maintain the requirements of the Rules as determined by the Program Coordinator**

I have included a copy of my curriculum vitae, medical license, proof of malpractice insurance, medical board certification (or board eligibility) and proof of attendance at an approved medical impairment rating course.

Signature_____ **Date**_____