

PHYSICIAN CREDENTIALING INFORMATION



833-277-3828

www.ime-plus.com

REGISTRATION FORM

Name:

TAX ID:

Practice Name:

Primary Practice Address where IME's are conducted:

Mailing Address:

Additional IME Locations:

Office Phone # Fax #

Scheduling Contact & Email:

Current Medical License

PLEASE ATTACH:

CURRENT FEE SCHEDULE

W9

SAMPLE REPORT

MEDICAL LICENSE

BOARD CERTIFICATION

LIABILITY INSURANCE

CURRENT CV

THANK YOU FOR YOUR INFORMATION

PHYSICIAN

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Please answer the following questions

Circle appropriate response

Has your license to practice in any jurisdiction ever been surrendered, limited, suspended, revoked, placed on probation, involuntarily relinquished or otherwise had conditions placed upon it?

Yes

No

Have your privileges at any hospital or other healthcare facility ever been suspended, diminished, revoked or not renewed?

Yes

No

Have you been refused a requested specialty medical or professional society membership?

Yes

No

Have you ever been asked to resign or not renew a specialty, medical or professional society membership?

Yes

No

Have you ever been refused medical malpractice insurance or been refused renewal of your medical malpractice insurance?

Yes

No

In the last 5 years, have you had an alleged medical malpractice action filed against you that resulted in an out-of-court settlement, or judgment against you?

Yes

No

Do you have any alleged medical malpractice actions filed against you pending or have suspicion of an imminent such action against you?

Yes

No

Have you ever been convicted of a felony?

Yes

No

Signature

Date

THANK YOU FOR YOUR INFORMATION