TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

For TDI-DWC Use Only

Application Approved _____
Date Licensure Verified _____
Verification Received From _____

Medical Quality Review Panel Application

I. APPLICANT / INDIVIDUAL INFORMATION

1. Name (Last, First, Middle, Suffix)	**2. Social Security Number**
3. Home Mailing Address (Street or PO Box, City, State, Zip Code)	**4. Date of Birth** (mm/dd/yyyy)
5. Business Mailing Address (Street or PO Box, City, State, Zip Code)	
6. Home Phone Number ( )	**7. Alternate Phone Number** ( )
8. Fax Number ( )	**9. E-mail Address**

II. TEXAS LICENSE INFORMATION (attach additional pages, if necessary)

10. License Type	**11. License Number**
12. Original Date of Issue (mm/dd/yyyy)	**13. Expiration Date** (mm/dd/yyyy)

III. PROFESSIONAL SPECIALTY INFORMATION (attach additional pages, if necessary)

14. Primary Specialty _____ Are you board certified in this specialty? ☐ Yes ☐ No
If yes, provide the following information:
Name of certifying board _____
Initial certification date _____
Recertification dates (if applicable) _____
Expiration date (if applicable) _____

15. Secondary Specialty _____ Are you board certified in this specialty? ☐ Yes ☐ No
If yes, provide the following information:
Name of certifying board _____
Initial certification date _____
Recertification dates (if applicable) _____
Expiration date (if applicable) _____

16. Additional Specialty _____ Are you board certified in this specialty? ☐ Yes ☐ No
If yes, provide the following information:
Name of certifying board _____
Initial certification date _____
Recertification dates (if applicable) _____
Expiration date (if applicable) _____

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IV. EDUCATION (attach additional pages, if necessary)

17. Professional Degree ☐ Medical/Osteopathic ☐ Chiropractic ☐ Optometry ☐ Podiatry ☐ Dentistry ☐ Other	
18. Institution	**19. Degree**
20. Address	**21. Attendance Dates** (mm/yyyy) From to
22. Post-Graduate Education ☐ Internship ☐ Residency ☐Fellowship ☐ Teaching Appointment	**23. Specialty**
24. Institution	**25. Attendance Dates** (mm/yyyy) From to
26. Address (Street or PO Box, City, State, Zip Code)	**27. Program Completed Successfully** ☐ Yes ☐ No
28. Program Director	**29. Current Program Director** (if known)
30. Post-Graduate Education ☐ Internship ☐ Residency ☐Fellowship ☐ Teaching Appointment	**31. Specialty**
32. Institution	**33. Attendance Dates** (mm/yyyy) From to
34. Address (Street or PO Box, City, State, Zip Code)	**35. Program Completed Successfully** ☐ Yes ☐ No
36. Program Director	**37. Current Program Director** (if known)
38. Other Graduate-Level Education Field of study	
39. Institution	**40. Degree**
41. Address (Street or PO Box, City, State, Zip Code)	**42. Attendance Dates** (mm/yyyy) From to

V. ACTIVE PRACTICE / WORK HISTORY INFORMATION

Active Practice	
43. During the last 2 calendar years, at the time of appointment, did you maintain an active practice*? ☐ Yes ☐ No *Active practice is defined in 28 Texas Administrative Code, §180.62 (d)(3) as actively diagnosed or treated persons at least 20 hours per week for 40 weeks duration during a given calendar year or performed administrative, leadership, or advisory roles in the practice of medicine.	
Work History **List all current and previous practice locations** (attach additional pages, if necessary)	
44. Current Practice / Employer Name (if any)	**45. Start Date / End Date** (mm/yyyy) From to
46. Address (Street or PO Box, City, State, Zip Code)	**47. Position**
48. Previous Practice / Employer Name	**49. Start Date / End Date** (mm/yyyy) From to
50. Address (Street or PO Box, City, State, Zip Code)	**51. Position**
52. Previous Practice / Employer Name	**53. Start Date / End Date** (mm/yyyy) From to
54. Address (Street or PO Box, City, State, Zip Code)	**55. Position**

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VI. CERTIFIED WORKERS' COMPENSATION HEALTH CARE NETWORK AFFILIATIONS

List all current certified workers' compensation health care network (network) affiliation(s) pursuant to Insurance Code Chapter 1305 and affiliation(s) with political subdivision health plan(s) pursuant to Texas Labor Code §504.053(b)(2). Enter the contract start date for each network and each political subdivision health plan. (attach additional pages, if necessary)	
56. Network / Political Subdivision Health Plan Name	**57. Start Date** (mm/dd/yyyy)
58. Network / Political Subdivision Health Plan Name	**59. Start Date** (mm/dd/yyyy)
60. Network / Political Subdivision Health Plan Name	**61. Start Date** (mm/dd/yyyy)

VII. MEDICAL REVIEW AFFILIATIONS

List all current and past medical review affiliations (independent review organization, utilization review agent, licensing board, insurance carrier, and other) (attach additional pages, if necessary)		
62. Company Name	**63. Position**	**64. Start Date** (mm/dd/yyyy)
65. Description of Services Provided		
66. Company Name	**67. Position**	**68. Start Date** (mm/dd/yyyy)
69. Description of Services Provided		

VIII. SUMMARY OF FINANCIAL ARRANGEMENTS

List all current financial arrangements pursuant to 28 Texas Administrative Code, §180.64(b)(9) (attach additional pages, if necessary)	
70. Company Name	**71. Start Date** (mm/dd/yyyy)
72. Check one box to indicate the type of financial arrangement*: ☐ Ownership interest ☐ Salaried ☐ Contract	
73. Description of ownership interest or other financial arrangement*	
74. Company Name	**75. Start Date** (mm/dd/yyyy)
76. Check one box to indicate the type of financial arrangement*: ☐ Ownership interest ☐ Salaried ☐ Contract	
77. Description of ownership interest or other financial arrangement*	
*includes any financial arrangement involving a person or agent who is subject to the Texas Labor Code or a rule, order or decision of the Commissioner of Workers' Compensation	

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IX. DISCLOSURE QUESTIONS (check **YES** or **NO** for each question)

78. *Licensure*	**YES**	**NO**
Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation, or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board?	☐	☐
Have you ever received a reprimand or been fined by any state licensing board?	☐	☐
79. *Hospital Privileges and Other Affiliations*	**YES**	**NO**
Have your clinical privileges or Medical Staff membership at any hospital or health care institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or health care institution, medical staff or committee, or governing board?	☐	☐
Have you ever voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?	☐	☐
Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?	☐	☐
80. *Education, Training and Board Certification*	**YES**	**NO**
Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?	☐	☐
Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?	☐	☐
Have any of your board certifications or eligibility ever been revoked?	☐	☐
Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?	☐	☐
81. *DEA (Drug Enforcement Administration) or DPS (Department of Public Safety)*	**YES**	**NO**
Have your Federal DEA and/or DPS Controlled Substances Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?	☐	☐
82. *Medicare, Medicaid or other Governmental Program Participation*	**YES**	**NO**
Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?	☐	☐
Other sanctions or investigations?	☐	☐
Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or DPS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program?	☐	☐
To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?	☐	☐

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Have you ever received sanctions from or been the subject of investigation by any regulatory agency (e.g., CLIA, OSHA, etc.)?	☐	☐
Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or health care facility of any military agency?	☐	☐
83. *Malpractice Claims History*	**YES**	**NO**
Have you had any malpractice actions within the past 5 years (pending, settled, arbitrated, mediated or litigated)?	☐	☐
84. *Criminal*	**YES**	**NO**
Have you ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony that is reasonably related to your qualifications, competence, functions, or duties as a medical professional?	☐	☐
Have you ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony including an act of violence, child abuse or a sexual offense?	☐	☐
Have you ever been court-martialed for actions related to your duties as a medical professional?	☐	☐
85. *Ability to Perform Job*	**YES**	**NO**
Are you currently engaged in the illegal use of drugs? NOTE: "Currently" means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. §812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.	☐	☐
Do you use alcohol or any chemical substance that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?	☐	☐
Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?	☐	☐

86. *Disclosure Explanations* (attach additional pages, if necessary)

If you answered “Yes” to any question(s), identify each question by number and explain below.

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X. APPLICANT'S AUTHORIZATION, ATTESTATION AND RELEASE

I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) or its designated agent, information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for participation in, or with, the TDI-DWC. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

I certify that all information provided in this application is true, complete, and correct to the best of my knowledge, and that I will notify the TDI-DWC within 10 working days of any change to the information I have provided in my application or authorized to be released pursuant to the credentialing process.

I understand that I am required on my own initiative to report to the TDI-DWC any changes to the application within 30 days of the date the information changed, or from the date I become aware of such changes, and that all changes must be submitted in writing, and must be dated and signed by me.

I am aware that participation in the Texas workers' compensation system as a Medical Quality Review Panel member is not a right and is conditioned upon compliance with the Texas Labor Code and TDI-DWC rules and my provision of quality health care, evaluations, and/or medical opinions.

I affirm that I will remain aware of and in compliance with the requirements of the Texas Labor Code and TDI-DWC rules, including but not limited to:

- financial disclosure requirements as contained in the Texas Labor Code, §413.041;
- confidentiality provisions, pursuant to 28 Texas Administrative Code, §180.64(b)(12);
- cooperating with TDI-DWC monitoring and review efforts such as audits by the TDI-DWC;
- paying audit bills when required by the Texas Labor Code or TDI-DWC rules; and
- owning or maintaining subscriptions to the current editions of guidelines adopted by the TDI-DWC, including impairment rating, treatment, and return-to-work guidelines.

I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial of application; and/or immediate suspension or termination of membership.

87. Signature of Applicant	
88. Printed Name of Applicant	**89. Date of Signature** (mm/dd/yyyy)
Mail the completed DWC Form-072, *Medical Quality Review Panel Application*, and any attachments to:	Texas Department of Insurance Division of Workers' Compensation PO Box 12050 Austin, TX 78711

NOTE[1]: Title 28 Texas Administrative Code §180.64(a) specifies that in order to apply to the MQRP, a person must submit an application in the form and manner required by TDI-DWC. The social security number may be used to identify the applicant.

Note: With few exceptions, on your request, you are entitled to:

- be informed about the information DWC collects about you;
- receive and review the information (Government Code Sections 552.021 and 552.023); and
- have DWC correct information that is incorrect (Government Code Section 559.004).

For more information, contact DWCLegalServices@tdi.texas.gov or refer to the Corrections Procedure section at www.tdi.texas.gov/commissioner/legal/lccorprc.html

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