PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Designated doctor certification application

Date current certification expires, if applicable

(mm/yyyy) ____________________

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Part 1. Applicant (**not** administrative services company or agent information)

1. Name (first, middle, last)	**2. Social Security number**	**3. Date of birth** (mm/dd/yyyy)
4. Home mailing address (street or PO box, city, state, Zip code)		
5. Business mailing address (street or PO box, city, state, Zip code)		
6. Home phone number	**7. Business phone number**	**8. Cell Phone Number**
9. Fax number	**10. E-mail address**	
11a. Non-English language spoken by applicant ☐ Yes ☐ No If yes, specify		
11b. Non-English language spoken by office personnel ☐ Yes ☐ No If yes, specify		

Part 2. Licenses (Attach additional pages, if necessary.)

Texas license	**Other license** (if applicable)	**Other license** (if applicable)
12. License type	**17. License type**	**22. License type**
13. License number	**18. License number**	**23. License number**
14. State of registration **Texas**	**19. State of registration**	**24. State of registration**
15. Original date of issue (mm/yyyy)	**20. Original date of issue** (mm/yyyy)	**25. Original date of issue** (mm/yyyy)
16. Expiration Date (mm/yyyy)	**21. Expiration Date** (mm/yyyy)	**26. Expiration Date** (mm/yyyy)

Part 3. Professional specialties – M.D. or D.O. only (Attach additional pages, if necessary.)

List professional specialties	Provide the applicable dates (mm/yyyy)
27. Primary Specialty: Indicate your board certification for this specialty. ☐ ABMS ☐ AOABOS ☐ None	Initial certification: Recertification(s): Expiration:
28. Secondary Specialty: Indicate your board certification for this specialty. ☐ ABMS ☐ AOABOS ☐ None	Initial certification: Recertification(s): Expiration:
29. Additional Specialty: Indicate your board certification for this specialty. ☐ ABMS ☐ AOABOS ☐ None	Initial certification: Recertification(s): Expiration:

Note: The applicant may be required to present ABMS or AOABOS documentation for verification purposes.

Part 4. Education (Attach additional pages, if necessary.)

30. Professional degree
☐ **Medical/Osteopathic** ☐ **Chiropractic** ☐ **Optometry** ☐ **Podiatry** ☐ **Dentistry**

31. Institution	**32. Degree**	**33. Attendance dates** (mm/yyyy) From to
34. Address (street or PO box, city, state, Zip code)		
35. Post-graduate education ☐ **Internship** ☐ **Residency** ☐ **Fellowship** ☐ **Teaching appointment**	**36. Program director**	**37. Current program director** (if known)
38. Institution	**39. Program specialty**	**40. Attendance dates** (mm/yyyy) From to
41. Address (street or PO box, city, state, Zip code)		**42. Program completed successfully?** ☐ **Yes** ☐ **No**

Applicant's name:

Texas license #:

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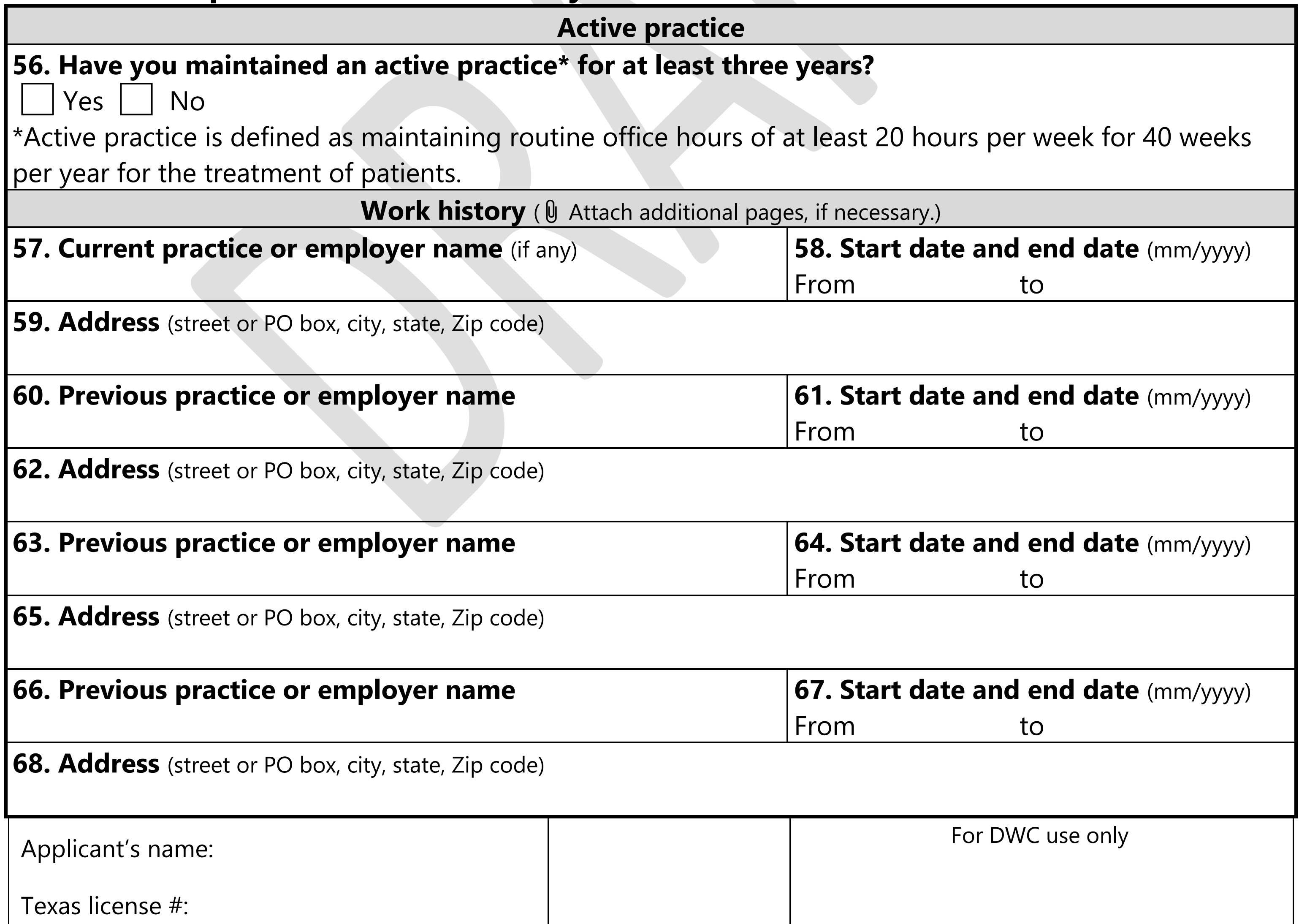
43. Post-graduate education ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching appointment	44. Program director	45. Current program director (if known)
46. Institution	47. Program specialty	48. Attendance dates (mm/yyyy) From to
49. Address (street or PO box, city, state, Zip code)		50. Program completed successfully? ☐ Yes ☐ No

51. Other graduate-level education - Field of study		
52. Institution	53. Degree	54. Attendance dates (mm/yyyy) From to
55. Address (street or PO box, city, state, Zip code)		

Part 5. Active practice and work history



Active practice	
56. Have you maintained an active practice* for at least three years? ☐ Yes ☐ No *Active practice is defined as maintaining routine office hours of at least 20 hours per week for 40 weeks per year for the treatment of patients.	
Work history (Attach additional pages, if necessary.)	
57. Current practice or employer name (if any)	58. Start date and end date (mm/yyyy) From to
59. Address (street or PO box, city, state, Zip code)	
60. Previous practice or employer name	61. Start date and end date (mm/yyyy) From to
62. Address (street or PO box, city, state, Zip code)	
63. Previous practice or employer name	64. Start date and end date (mm/yyyy) From to
65. Address (street or PO box, city, state, Zip code)	
66. Previous practice or employer name	67. Start date and end date (mm/yyyy) From to
68. Address (street or PO box, city, state, Zip code)	

Applicant's name: Texas license #:	For DWC use only

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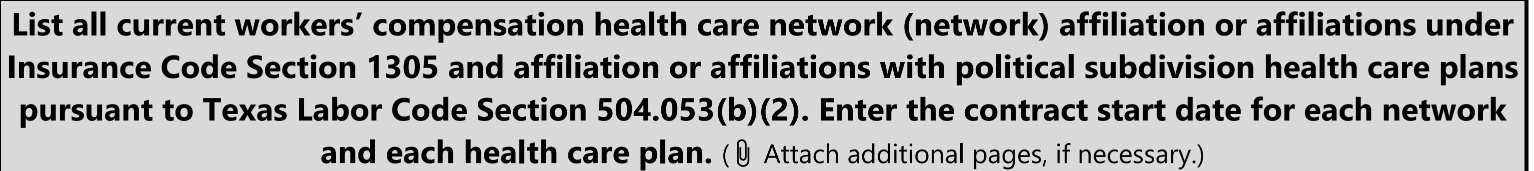
Part 6. Workers' compensation health care network affiliations



List all current workers' compensation health care network (network) affiliation or affiliations under Insurance Code Section 1305 and affiliation or affiliations with political subdivision health care plans pursuant to Texas Labor Code Section 504.053(b)(2). Enter the contract start date for each network and each health care plan. (Attach additional pages, if necessary.)

69. Network or health care plan name	**70. Start date** (mm/dd/yyyy)
71. Network or health care plan name	**72. Start date** (mm/dd/yyyy)
73. Network or health care plan name	**74. Start date** (mm/dd/yyyy)

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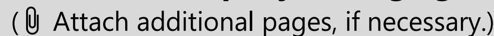
Part 7. Administrative services company, billing agent and other affiliations

List all current administrative services company, billing agent and other agent affiliations



(Attach additional pages, if necessary.)

75. Administrative services company or agent name	**76. Contract start date** (mm/dd/yyyy)
77. Administrative services company or agent name address (street or PO box, city, state, Zip code)	
78. Name of point of contact	**79. Phone number of point of contact**
80. Email address of point of contact	**81. Fax number of point of contact**
82. Billing agent name	**83. Billing agent phone number**

Part 8. Disclosure questions (check **Yes** or **No** for each question)

84. *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 or state or federal agency, including DWC?	☐	☐
Have you or your professional practice ever received a reprimand or been fined by any state licensing board or state or federal agency, including DWC?	☐	☐

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Texas license #:

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85. ***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 health care management organizations, preferred provider organizations or provider organizations such as independent physician associations, physician hospital associations)?	☐	☐
86. ***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 or certifications while under investigation?	☐	☐
87. ***Drug Enforcement Administration (DEA) or Department of Public Safety (DPS)***	**Yes**	**No**
Have your federal DEA or DPS controlled substances certificate or authorization ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?	☐	☐
88. ***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?	☐	☐

Applicant's name:

Texas license #:

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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?	☐	☐
Have you ever received sanctions from or been the subject of investigation by any regulatory agency such as Clinical Laboratory Improvement Amendments or National Institutes for Occupational Safety and Health?	☐	☐
Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency?	☐	☐
Have you ever been terminated or resigned while under investigation by a hospital or health care facility of any military agency?	☐	☐
89. *Malpractice claims history*	**Yes**	**No**
Have you had any active or pending malpractice claims or at any time during the past five years?	☐	☐
90. *Criminal*	**Yes**	**No**
Have you ever been convicted of, pled guilty to, or pled no contest 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 no contest 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?	☐	☐
91. *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. Section 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.	☐	☐

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Do you use any chemical substances 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 injured employees or other system participants?	☐	☐
Are you unable to perform the essential functions of a designated doctor as specified in 28 Texas Administrative Code, Chapter 127 and other applicable provisions of DWC rules and the Texas Labor Code?	☐	☐

92. *Disclosure explanations* (Attach additional pages, if necessary.)

If you answered "Yes" to any question, identify each question by number and explain in detail below.

Part 9. Applicant's authorization, attestation, and release

I authorize any third party to release to the Texas Department of Insurance, Division of Workers' Compensation (DWC), information, including otherwise privileged or confidential information.

- Third parties include, but are 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.
- The types of information I authorize a third-party to release include, but are not limited to: 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, DWC.

I specifically waive written notice from any entities and individuals who provide information based on 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
- I will notify DWC within 10 working days of any change to the information I have provided in my application.

Applicant's name: Texas license #:		For DWC use only

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I am aware that participation in the Texas workers' compensation system as a designated doctor is not a right and my delivery of quality health care, evaluations, or medical opinions is conditioned on compliance with statute and rules.

I affirm that I will remain aware of and comply with the requirements of statute and DWC rules. This includes but is not limited to:

- filing financial disclosure requirements as described in Labor Code, Section 413.041;
- cooperating with DWC monitoring and review efforts such as audits by DWC;
- paying audit bills when required by statute or rule;
- providing updated information to DWC under 28 TAC Section 127.200(a)(8);
- consenting to on-site visits consistent with 28 TAC Section 127.200 (a)(15); and
- owning or maintaining subscriptions to the current editions of guidelines adopted by the DWC, including impairment rating, treatment, and return-to-work guidelines.

I agree that any material misstatement or omission in the application may result in delay, denial, revocation or immediate suspension or termination of certification.

93. Signature of applicant	
94. Printed name of applicant	**95. Date of signature** (mm/dd/yyyy)

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Applicant's name:

Texas license #:

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FAQ
Designated doctor certification application

Who can use this application?

Doctors, including doctors of medicine, doctors of osteopathic medicine, doctors of chiropractic, doctors of dentistry, doctors of optometry and doctors of podiatry, may use this form to apply for or renew a designated doctor certification.

When must I apply for renewal?

A designated doctor who seeks to renew their certification immediately after their current term expires, without interruption, must apply for certification no later than 45 days before the end of the term. DWC will not assign exams during the last 45 days of an expiring term if we have not received all of the information required under 28 Texas Administrative Code Section 127.100(b)(1)-(9).

Where do I send this application?

Fax the completed DWC Form-067, *Designated doctor certification application*, and attachments to 512-804-4207 or by mail:

Texas Department of Insurance
Division of Workers' Compensation
PO Box 12050, MC-HS-OMA
Austin, Texas 78711

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Note: With few exceptions, on your application, 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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