2902 CROSSING COURT, SUITE C • CHAMPAIGN, IL 61822
PH: (217) 352-1060 • (800) 635-9407 • FAX: (217) 352-1182
Website: www.cimro.com

PHYSICIAN MEMBERSHIP APPLICATION

PLEASE IDENTIFY ORDER OF PREFERENCE FOR CONTACTING YOU:

		ORDER
WORK TELEPHONE:		
FAX:		
HOME TELEPHONE:		
PAGER:		
CELL:		
E-MAIL:		
CONTACT PERSON:		

_____
(Last) *(First)* *(MI)*

DATE OF BIRTH: _____ **SS#:** _____

MAILING ADDRESS: _____

_____

_____

_____

UPS CHARTS ADDRESS: _____

_____

_____

LICENSE (S): State: _____ # _____ Year Licensed: _____
State: _____ # _____ Year Licensed: _____
State: _____ # _____ Year Licensed: _____

I WISH TO BECOME A: MEMBER _____ PHYSICIAN REVIEWER CONSULTANT _____ ECFMG: # _____

Are you actively engaged in the practice of medicine/surgery? ___ Yes ___No Hours each week devoted to active practice: _____

Does your practice include the care and treatment of Medicare beneficiaries? ___Yes ___No Medicaid recipients? ___Yes ___No

How did you learn of this opportunity? _____

SPECIALTY/SUB-SPECIALTIES

_____ Board Certified? ___Yes ___No

_____ Board Certified? ___Yes ___No

For which of the above specialties do you prefer to perform case review? All? ___Yes ___ No

If NO, Prefer only: _____

List any focus areas within your field of practice (e.g., eating disorders, pain management, infertility, specialty surgeries, etc)

_____

_____

Are you willing to participate in a fair hearing by teleconference? ____Yes ____No (We are NOT referring to expert testimony in a court of law; this means discussion of your review and rationale with the facility and practitioner under review. Separate rates are negotiated for this service.)

Are you willing to perform expedited reviews requiring: **ONE**-day turnaround? ____Yes ____No

F**IVE**-day turnaround? ____Yes ____No

Are you willing to provide your signature on the report determination supplied to a CIMRO client? ____Yes ____No

Are you willing to have your CV released to a CIMRO client upon request? ____Yes ____No

ACTIVE STAFF PRIVILEGES

HOSPITAL NAME	CITY

Courtesy Privileges: _____

Practice Setting (Admitting Privileges): ___Urban (200+ beds and/or Level 1 Trauma); ___ Intermediate (100-199 beds); ___ Rural (<100 beds)

Please return this application and the following items to CIMRO:

1. A copy of current License and Controlled Substances License
2. A copy of other state medical license(s), if applicable
3. A copy of Board Certificate(s), if applicable
4. Signed Confidentiality Statement
5. Current Curriculum Vitae
6. Request for Taxpayer Identification Number and Certification Form

I hereby authorize CIMRO to contact the hospital at which I practice for the purpose of verification of my admitting privileges, license number, and informal reference.

Signature: _____ Date: _____