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

PEER REVIEWER APPLICATION

Identify Preference Order to Contact You

		ORDER
WORK TELEPHONE:		
FAX:		
HOME TELEPHONE:		
CELL:		
E-MAIL:		

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

DATE OF BIRTH: _____ GENDER: ☐ M ☐ F

MAILING ADDRESS: _____

_____

_____

CONTACT PERSON: _____

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

Are you actively engaged in the practice of medicine/surgery? ☐ Yes ☐ No Hours each week devoted to active practice: _____
If no, please describe your practice setting and how you stay current with standards of practice (e.g. CMEs).

_____

_____

How did you learn of this opportunity? _____

SPECIALTY/SUB-SPECIALTIES

_____ BC Yes☐ No☐ N/A☐ Certifying body_____
_____ BC Yes☐ No☐ N/A☐ Certifying body_____
_____ BC Yes☐ No☐ N/A☐ Certifying body_____

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 at the client's location? ☐ Yes ☐ No
Are you willing to participate in a fair hearing via 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 with your input.)
Are you willing to have your CV released to a CIMRO client upon request? ☐ Yes ☐ No
(If your answer is no, please provide a redacted CV.)

ACTIVE STAFF/ ADMITTING PRIVILEGES, if applicable. If not applicable, please describe below:

_____

_____

HOSPITAL NAME	BED SIZE	CITY	STATE

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. Furthermore, by signing this I attest that:

1. I have no conflict of interest with CIMRO;
2. My licenses, certifications, registrations and/or hospital privileges (as applicable) to provide health care services are current, unrestricted and not subject to investigation;
3. I am in active practice with at least two years of experience; and
4. All reportable and/or discoverable license actions, complaints, state-level corrective action plan(s), and/or malpractice settlements for which I or my representative was required to pay, etc. have been fully disclosed.

Signature: _____ **Date:** _____

Visit CIMRO's Peer Reviewer Portal at www.cimro.com to see resource documents.