

FORM 626

APPLICATION FOR MEDICAL CASE MANAGER

- Initial Application
 Renewal

Please complete the following, sign under penalty of perjury and return with a current resume to the:
WORKERS' COMPENSATION COURT
ATTENTION: MEDICAL SERVICES DIVISION
1915 NORTH STILES AVENUE
OKLAHOMA CITY, OKLAHOMA 73105-4918

ALL INFORMATION SUBMITTED TO THE COURT MAY BE CONSIDERED A PUBLIC RECORD UNDER STATE LAW. Direct all questions concerning disclosures to the Medical Services Division.

Applicant's Name:		Name of Place of Business:		THIS SPACE FOR OFFICE USE ONLY	
Office Address:		City	State		Zip
Mailing Address:		City	State		Zip
Office Phone:	Name of Contact Person to Confirm Availability for Court Appointment:				

1. Professional Credentials R.N. (Oklahoma License No. _____) CDMS CCM CRRN CMC COHN COHN-S
(Attach a copy of your current professional license/case management certification, clearly marked as "COPY.")

NOTE: If you answer YES to question(s) 2, 3 and/or 4, provide an explanation on each on a separate sheet and attach to this application.

2. Has your professional license or case management certification ever been revoked or suspended by the issuer of such license or certification? Yes No
3. Have you ever had any Disciplinary Actions, past or present, filed against you by your professional licensing body or case management certification entity?
 Yes No
4. Have you been convicted of a felony under federal or state law within 7 years before the date of this application? Yes No
5. Do you have any experience or education concerning workers' compensation principles or the Oklahoma workers' compensation system? Yes No
If yes, please list: _____
6. List types of medical cases you do NOT want referred to you: _____
7. Do you do telephone case management? Yes No If yes, what are your estimated fees? _____
8. Do you provide in-person case management services? Yes No If yes, list city(ies) in which you will provide in-person case management services:

If you provide in-person case management services, what are your estimated fees? _____
9. Attach a list of each employer, insurer, employer group, certified workplace medical plan, or any representative thereof with whom you are under contract as a case manager or who regularly uses your case management services. (Please type or print.)

I request appointment to the list of Medical Case Managers maintained by the Oklahoma Workers' Compensation Court. I will provide independent, impartial and objective medical case management services in all cases to which I am assigned. I will decline a request to serve as a medical case manager only for good cause shown. I will meet with the worker and appear at appointments by treating physicians as directed by the Court and as necessary to respond to Court inquiries. I will submit an initial written report within twenty calendar days of the order appointing me as the case manager and progress reports as necessary or as directed by the Court. I will notify the Workers' Compensation Court in writing upon any change affecting my qualifications as a medical case manager. If I am appointed to the list of Medical Case Managers, I agree to serve for a 2-year period. I agree to abide by all applicable statutes and Court rules.

I authorize all associations, organizations and State and Federal agencies to release to the Oklahoma Workers' Compensation Court all relevant documents and information that may be required in the investigation of this application. I hereby certify that my professional license/certification as a case manager is in good standing.

I declare under PENALTY OF PERJURY that the statements contained herein are true and correct to the best of my knowledge and belief. I understand that false or misleading information may result in the rejection of my application or my removal from the list if I am appointed.

SIGNATURE

2/06

DATE