PDC
IME NETWORK CLINICIAN INQUIRY FORM

If you are interested in joining the IME Network, we ask that you provide the following information, and return the completed form by mail, fax or electronically to PDC, Attn: *IME Coordinator.* Once we receive your completed form, we will mail you an application and informational brochure. Phone inquiries are also welcome.

NAME: (Please type or print clearly) _____ _____ Administrative Contact Person	**MAILING ADDRESS:** _____ _____ _____ City, State, Zip Code
CONTACT INFORMATION: Direct phone # _____ Administrative #_____ Fax # _____ Email _____	**CLINICAL SPECIALITY:** _____ **BOARD CERTIFICATION(S):** _____ Year _____ Year
PRACTICE BREAKDOWN: (recent 5 year average – must total 100%) Direct patient care or consultations _____ % Academic _____ % Research _____ % IME/FCE of any kind _____ % Other forensic or Medical/Legal _____ % Other (define)_____ % Additional Comments:	**MEDICAL/LEGAL ACTIVITY:** (check one): (recent 5 year average) Defense based _____ Plaintiff based _____ Mixed _____

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Received:_____