TDI Division of Workers' Compensation

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

DESIGNATED DOCTOR CERTIFICATION APPLICATION

☐ **Initial Certification**
☐ **Recertification**

Date current certification expires, if applicable

_____(mm/yyyy)

I. APPLICANT / INDIVIDUAL INFORMATION (**not** administrative services company/agent information)

1. Name (Last, First, Middle, Suffix)	**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	

II. LICENSE INFORMATION (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)

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III. PROFESSIONAL SPECIALTY INFORMATION - MD/DO 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.	

IV. 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
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)		

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V. ACTIVE PRACTICE / WORK HISTORY INFORMATION

Active Practice	
56. Have you maintained an active practice* for at least 3 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 / Employer Name (if any)	**58. Start Date / End Date** (mm/yyyy) From to
59. Address (Street or PO Box, City, State, ZIP Code)	
60. Previous Practice / Employer Name	**61. Start Date / End Date** (mm/yyyy) From to
62. Address (Street or PO Box, City, State, ZIP Code)	
63. Previous Practice / Employer Name	**64. Start Date / End Date** (mm/yyyy) From to
65. Address (Street or PO Box, City, State, ZIP Code)	
66. Previous Practice / Employer Name	**67. Start Date / End Date** (mm/yyyy) From to
68. Address (Street or PO Box, City, State, ZIP Code)	

VI. WORKERS' COMPENSATION HEALTH CARE NETWORK AFFILIATIONS

List all current workers' compensation health care network (network) affiliation(s) pursuant to Insurance Code §1305 and affiliation(s) with political subdivision health care plan(s) pursuant to Texas Labor Code §504.053(b)(2). Enter the contract start date for each network and each health care plan. (attach additional pages, if necessary)	
69. Network / Health Care Plan Name	**70. Start Date** (mm/dd/yyyy)
71. Network / Health Care Plan Name	**72. Start Date** (mm/dd/yyyy)
73. Network / Health Care Plan Name	**74. Start Date** (mm/dd/yyyy)

VII. ADMINISTRATIVE SERVICES COMPANY / BILLING AGENT / OTHER AGENT AFFILIATIONS

List all current administrative services company, billing agent, and other agent affiliation(s) (attach additional pages, if necessary)	
75. Administrative Services Company / Agent Name	**76. Contract Start Date** (mm/dd/yyyy)
77. Administrative Services Company / Agent Address (Street or PO Box, City, State, ZIP Code)	
78. Name of Point of Contact	**79. Phone Number of Point of Contact** ( )
80. E-mail Address of Point of Contact	**81. Fax Number of Point of Contact** ( )
82. Billing Agent Name	**83. Billing Agent Phone Number** ( )

Applicant's Name: Texas License #:	For TDI-DWC Use Only

VIII. 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, disciplinary action, remedial plan, probation or any conditions or limitations by any state licensing board or state or federal agency, including TDI-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 TDI-DWC?	☐	☐
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 HMOs, PPOs, or provider organizations such as IPAs, PHOs)?	☐	☐
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(s) while under investigation?	☐	☐
87. *DEA (Drug Enforcement Administration) or DPS (Department of Public Safety)*	**YES**	**NO**
Have your Federal DEA and/or DPS Controlled Substances Certificate(s) or authorization(s) 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?	☐	☐
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 (e.g., CLIA, OSHA, etc.)?	☐	☐

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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/pending malpractice claims/actions at any time during the past 5 years?	☐	☐
90. *Criminal*	**YES**	**NO**
Have you ever been convicted of, pled guilty to, or pled *nolo contendere* 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 *nolo contendere* 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 one's profession. 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. §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.	☐	☐
Do you use any chemical substances that would in any way impair or limit your ability to practice your profession 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 TDI-DWC rules and the Texas Labor Code?	☐	☐
92. *Disclosure Explanations* (attach additional pages, if necessary)		
If you answered “Yes” to any question(s), identify each question by number and explain below.		

NOTE: With few exceptions, upon your request, you are entitled to be informed about the information TDI-DWC collects about you; get and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004). For more information, contact agencycounsel@tdi.texas.gov or you may refer to the Corrections Procedure section at www.tdi.texas.gov.

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IX. APPLICANT'S AUTHORIZATION, ATTESTATION AND RELEASE

I authorize any third party, including, but 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, to release to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC), information, including otherwise privileged or confidential information, concerning my 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, the TDI-DWC. I specifically waive written notice from any entities and individuals who provide information based upon 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. I understand that I am required on my own initiative to report to the TDI-DWC any updated information within 10 working days of a change in any of the information provided to the division on the doctor's application for certification or recertification as a designated doctor.

I am aware that participation in the Texas workers' compensation system as a designated doctor is not a right and is conditioned upon compliance with Title 5 of the Labor Code and TDI-DWC rules and my provision of quality health care, evaluations, and/or medical opinions.

I affirm that I will remain aware of and in compliance with the requirements of the statutes and TDI-DWC rules, including but not limited to:

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

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

93. Signature of Applicant	
94. Printed Name of Applicant	**95. Date of Signature** (mm/dd/yyyy)

X. SUBMISSION INSTRUCTIONS

96. Check and attach the following required documents:

☐ Copy of Designated Doctor Training Certificate(s) ☐ Copy of Designated Doctor Testing Certificate(s)

Mail the completed DWC Form-067, *Designated Doctor Certification Application*, and attachments to the following address or fax to (512) 804-4207:

Texas Department of Insurance
Division of Workers' Compensation
PO Box 12050
Austin, Texas 78711

Applicant's Name:

Texas License #:

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