DESIGNATED MEDICAL PROVIDER CHECKLIST

Clinic Information

Date:

Clinic Name: In Carrier's MPN: Y / N

Clinic Address:

Hours/After hour facility:

Phone: Fax:

Email:

Online portal:

Other locations:

Contacts:

Office Manager:

Medical Directory and specialty:

Other:

Communication: Describe doctor/office communication with employer and carrier

Questions

Question	Yes	No	Comments
Office visit results/ report turnaround time (same day?)			
Provide same day copy of Doctor's First Report and disability status reports			
Notice of change in medical status and progressive improvement in work ability			
Charge for missed appointments			
Modified/Alternative work status with specific Work Restrictions and Capabilities			
Address non occupational activities and prior medical history relevant to injury			
List of specialty referrals, i.e. hand specialists, orthopedists, and chiropractors			
Easy verbal access to doctor/ turnaround time -return phone calls or emails			
Advise of suspicious claims?			
Pre-Employment Screenings? Drug/Alcohol testing? Physicals? Physical agility/function tests?			

Ergonomic evaluations and cost?			
Bilingual capabilities?			
Clinic specializes in occupational treatment/How many years? Who owns clinic?			
Does treatment include health education?			
Clinic's computer system that allows employers to go online in real time to view employee status?			
How many full-time doctors? Years of experience? Board Certified in Occupational Medicine?			
Do you have injured employee sign an authorization form to release medical information?			

Additional Questions

1. Physical Therapy/Radiology on site?

2. Instills confidence and trust in all parties? Sports medicine approach to healing?

3. Familiar with ACOEM Guidelines and Workers' Comp reporting requirements?

General Comments and Appearance of Clinic

Other Employer References

Company	Contact Name	Contact Phone/Email

Other Employer References

Company	Contact Name	Contact Phone/Email

Employer Information for Clinic Protocols*

Name of Employer:

Contact Name:

Title:

Nature of business, number of employees:

Address:

Phone:

Email

WC insurance carrier or TPA:

Primary Contact:

Title:

Company:

Address:

Phone:

Fax:

Email

Return to Work:

- Copies of job descriptions (physical ability requirements)
- Copy of Employer's Return To Work Plan
- List of potential Temporary Alternative Duties for doctor to consider

**Reminder: Send update notice to clinic when changes occur*