

**FORM ME-05**

**Certification of Qualified Doctors under A.S. Workmen’s Compensation Act**

Instructions: Pursuant to A.S.C.A. §32.0638, no physician or doctor shall perform any physical examination under workmen’s compensation unless designated or approved by the Commission. For certification to facilitate examinations under the American Samoa Workmen’s Compensation Act, the physician or doctor must be complete and submit this application to the Commission’s Office.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. <b>Name of Applicant</b> (First, Middle, Last):   |  | 2. <b>Social Security No.:</b>                                |  | 3. <b>Date of Birth:</b>  |  |
| 4. <b>Sex:</b><br><input type="checkbox"/> Male   <input type="checkbox"/> Female  |  | 5. <b>Nationality:</b>  |  | 6. <b>Employment Status:</b><br><input type="checkbox"/> Employed   <input type="checkbox"/> Self-employed            |  |
| 7. <b>Name of Employer:</b>  |  | 8. <b>Total Years Employed with Employer:</b>                 |  | 9. <b>EIN No. (if self-employed)</b>  |  |
| 10. <b>Location of Business (if self-employed)</b>   |  | 11. <b>How long have you legally practiced medicine?</b>      |  | 12. <b>Primary Specialization:</b>  |  |
| 13. <b>Medical Degree:</b>   |  |   | 14. <b>Name of Medical School applicant obtained Medical Degree:</b>   |   |  |
| 15. <b>Do you have a Medical License?</b><br><input type="checkbox"/> Yes   <input type="checkbox"/> No  |  | 16. <b>Name of Medical Institute Issuing Medical License:</b> |  |   |  |
| 17. <b>Have you ever conducted any workmen’s compensation examination?</b><br><input type="checkbox"/> No<br><input type="checkbox"/> Yes (specify type of examination / eval conducted):  |  |   |  | 18. <b>Total years of experience in conducting workers compensation examinations and evaluations – if applicable:</b> |  |
| 19. <b>Do you own any edition of the American Medical Association on Permanent Impairment?</b><br><input type="checkbox"/> Yes   <input type="checkbox"/> No   |  |   | 20. <b>Are you certified to practice medicine in American Samoa?</b><br><input type="checkbox"/> Yes   <input type="checkbox"/> No |   |  |
| 21. <b>Employer – Mailing Address:</b>   |  |   | Telephone   Mobile No.:  |   |  |
|  |  |   | Email Address (if any):  |   |  |
| <p><b>22. Authorization:</b></p> <p><i>I hereby acknowledge as the physician or doctor aforementioned herein that the information provided within this form is both complete, accurate, and conforms with all the requirements set by the Workmen’s Compensation Commission. I also understand that by making any falsifying information or misrepresentation of myself under this application shall be considered a crime.</i></p> <p>(Sign Here): _____<br/>Physician’s Authorized Signature</p> <p>_____ Date</p> |  |   |  |   |  |

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**Instructions & Information**

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**I. Instructions on Form Submission:**

- (1) Complete and fill out the application form and submit to the Commission's Office for filing. Please print and provide only the application form on top.
- (2) The following required documentations must be enclosed and provided together with form during submission:

Required Documentation:

- i. Photo Identification
- ii. Copy of valid medical license
- iii. Copy of Medical Degree
- iv. Proof of employment status with the employer

**II. Qualification for Certification:**

- (1) Medical license by a recognized medical institute in the Territory, or in any of the states or territories of the United States of America;
- (2) Actively maintain a medical practice for 3 or more years;
- (3) Completed or taken certification courses or training on evaluating permanent impairment and other medical examinations as required for workmen's compensation matters using guidelines set by the American Medical Association;
- (4) Owns or subscribes to any edition of permanent impairment guide published by the American Medical Association;
- (5) Have successfully rendered more than three permanent impairment examinations; and
- (6) Other requirements as deemed necessary by the Commission.

**III. Rejection and Revocation of Designation and Certification:**

- (1) History and record of malpractice or any related violations;
- (2) Medical license revoked;
- (3) Retired
- (4) Has not practiced for more than 5 or more years;
- (5) Excessive pattern of overturned reports by the court;
- (6) Inability to provide examinations in a timely and proper manner;
- (7) Inability to apply and evaluate proper ratings using guidelines set by the American Medical Association on permanent impairment;
- (8) A record of making partial and discriminating examinations;
- (9) Has numerous complaints and grievance suits filed or raised by patients; and
- (10) Debarment