IAIME International Academy of Independent Medical Evaluators www.iaime.org

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Website: www.iaime.org

Current
Head & Shoulders
Photograph

(Polaroid Acceptable)

APPLICATION FOR MEMBERSHIP (ASSOCIATE)

Name of Sponsor (if applicable): _____

Signature of Sponsor : _____

NAME: **Please leave one blank space between first, middle and last names.**	Last Name First Name Middle Initial Degree: Title:_____
ADDRESS: **The preferred address will be used by this office for all mailings until you advise us of a change.**	Business Address Home Address **Preferred Mailing Address:** ☐ Business ☐ Home
TELEPHONE/FAX / E-MAIL NUMBERS:	Office Fax Home E-Mail Address (required)
DATE OF BIRTH	Month Day Year
TRAINING: **Please list** **(Attach copy of Highest Degree Earned)**	SCHOOL (Location) Exact Date(s) Inclusive From Month Day Year TO Month Day Year
POST GRADUATE TRAINING: **Please list all training**	INSTITUTION Specialty 1_____ Specialty 2_____ Exact Date(s) Inclusive From Month Day Year TO Month Day Year

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IAIME REQUIRED COURSEWORK: (MUST HAVE AT LEAST ONE IAIME COURSE IN PAST TWO YEARS TO APPLY)	IAIME COURSE: ☐☐ ☐☐ Month Year
CURRENT CV:	PLEASE PROVIDE A COPY OF CURRENT CURRICULUM VITAE
LICENSURE:	PLEASE SEND A COPY OF YOUR CURRENT STATE LICENSE (If Appropriate)
ACTIVITY IN DISABILITY EVALUATION:	How long has the evaluation of disability or impairment been a part of your professional activity? _____Years
RECOMMENDATIONS:	Provide two letters of recommendation from individuals familiar with your qualifications and standing in impairment evaluation (Peers), who are Members or Fellows of IAIME.
REFERENCES: (To contact as necessary) Please List Two Colleagues	_____ NAME _____ INSTITUTION _____ ADDRESS _____ ADDRESS2 _____ CITY ST ZIP _____ COUNTRY _____ TELEPHONE FAX _____ EMAIL _____ NAME _____ INSTITUTION _____ ADDRESS _____ ADDRESS2 _____ CITY ST ZIP _____ COUNTRY _____ TELEPHONE FAX _____ EMAIL
List Academic appointments and other professional organizations	Other Professional Memberships/Academic Appointments: _____ _____ _____ _____ _____ _____ _____ _____

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APPLICATION STATEMENT: I hereby make application to the **International Academy of Independent Medical Evaluators** for membership in accordance with and subject to the Board's rules and policies in effect from time to time and enclose a non-refundable fee to cover the review of my credentials.

I agree that the Board shall be the sole judge of my credentials and qualifications for membership certification, I agree that the Board may disqualify me if the Board determines any information furnished by me is false, that I did not comply with or violated the Board's rules and policies.

I agree that my professional qualifications, including my moral and ethical standing and my competence in clinical skills, will be evaluated by the Board and that the Board may make inquiry of the persons named in my application and of other persons, such as authorities of licensing bodies, hospitals or other institutions as the Board may deem appropriate with respect to such matters; and I agree that the sources and all information furnished to the Board in connection with its inquiry shall be confidential, and not subject to disclosure, through legal process or otherwise, to me or to anyone acting on my behalf.

I hereby declare under penalty of perjury that the information given in the application is true and correct to the best of my knowledge and belief.

I accept that a Business Relationship exists with IAIME and I will receive Educational Materials by Facsimile, E-Mail and Direct Mail.

Signature (Name in Full) _____ **Date**_____

Dues, as set by the IAIME Board of Directors, are not deductible as a charitable contribution but may be used as a business expense.

Checklist: (Please verify enclosures below)

- ☐ Photograph
- ☐ Degree
- ☐ CV
- ☐ Two letters of recommendation
- ☐ Copy of current state license (as appropriate)

For office use only (insert dates)

____ Receipt
____ Receipt of additional information
____ Membership Committee Approval

ASSOCIATE MEMBERSHIP DUES
(Dues period January 1 to December 31)

☐ $295 - Annual Dues

PAYMENT INFORMATION:

Payment Method: ☐ Check ☐ Visa ☐ MC ☐ Amex ☐ Discover

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Exp. Date ☐☐/☐☐ Signature: _____

Security Code: ☐☐☐☐