MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

Medical Peer Review Consultant Submission Form

Name:_____ Position: _____

Organization Name: _____

Address: _____

City:_____ State: _____ Zip: _____

Phone: _____ Fax:_____ E-mail:_____

Please describe your area(s) of expertise/specialty(ies):_____

_____

Are you board certified in your specialty(ies)? ☐ Yes ☐ No

Are you a member of the MMS? ☐ Yes ☐ No

I have an active license to practice medicine in the Commonwealth of Massachusetts. ☐ Yes ☐ No

My license number is:_____

Please list any hospital or other health care facility you are affiliated with: _____

_____

Have you ever served on a peer review committee? ☐ Yes ☐ No

How did you learn about the MMS's Medical Peer Review Consultant Referral List?

☐ MassMed.org ☐ An MMS publication (such as *Vital Signs*)

☐ My organization's medical peer review committee ☐ A colleague ☐ Other: _____

I understand that:

- By signing below, I am certifying that I have an active license to practice medicine in the Commonwealth of Massachusetts.
- The nature of the services and responsibilities and any compensation for services are to be agreed upon between my organization and the consultant.
- Physicians self-select for inclusion in the Medical Peer Review Consultant Referral List.
- The MMS does not evaluate the qualifications of or credential the physicians who request to be listed — the list is intended as a resource only.
- The MMS does not endorse or recommend any particular consultant.
- The MMS urges me to do due diligence before agreeing to serve as a consultant to any medical peer review committee.

Agreed to and accepted by:

Name and Title _____ Date_____

PLEASE FAX OR MAIL THIS FORM TO:

OFFICE OF THE GENERAL COUNSEL

860 WINTER STREET, WALTHAM, MA 02451-1411

FAX (781) 893-9369 PRCRegistry@listserv.massmed.org