Physiatrist's Voice

NEWSLETTER APRIL 2014

Enhancing Health And Function Through Education And Research In The Field Of Physical Medicine And Rehabilitation

In this issue

President's Address

Rigoberto Puente-Guzman, MD

Old and new unprecedented challenges loom in year 2014. Some will affect a subpart of our specialty more than others but in the long run all physiatrists in all subgroups will be affected. In the last couple years physiatrists involved in interventional pain subspecialty and electrodiagnostic medicine have been hit the hardest. Physicians are an obvious target for continued cuts in reimbursement by insurance and government agencies, increased regulatory control and interference of the patient doctor relationship and adding barriers for patient access to care. In addition there is increased demand of physician time for uncompensated non-patient-direct-contact work.

With the ICD-10 roll out this year; The 24% cut to physicians Medicare payments once temporary patches expire on March 31st , if nothing is done keeping a constant state of uncertainty until the Sustainable Growth Rate (SGR) is repealed; the extension of ARNP's scope of practice, pushing legislation at multiple fronts with most recent that of allowing ARNP's the ability to prescribe narcotics; Insurance reform, Obama Care's mandates with multiple executive temporary changes and exemptions and new insurance regulations and adjustments altering millions of patient's insurance coverage some for the better and others for the worse, with March 31st as the deadline when individuals who do not have insurance must enroll or pay a penalty fee; Increased red tape by insurance carriers making the practice of medicine more difficult by forcing patients to switch their drugs, doctors and limiting access to diagnostic and therapeutic interventions; After significant Reduction of Electrodiagnostic (EDX) medicine relative value units (RVUs) coding changes with significant reimbursement loss, now CMS is pushing for further loss of coverage of US and certain spinal procedure interventions; The move toward pay for performance medical model which may be positive if done well but can be catastrophic if not; Physician shortage; November elections with voting on legalization of medical marijuana, if approved will bring a plethora of new problems, questions and issues for the medical arena, employers, and other regulatory agencies in local, state, federal levels. These are just a few of the issues will continue to be confronted in the future. This is not the time to shy away but be more involved.

As taunting as these issues may appear, I truly believe that we can direct the course of medical practice change to have a positive effect on both our patients and fellow physiatrists and other specialty physicians, but to accomplish this we must remain active, involved and work together with other medical and non-medical organizations and societies. Our voice needs to be heard so we can influence these changes. We cannot assume that "others" will take care and represent us to address all these problems, but unfortunately, that assumption in part has lead us to our current state where instead of physicians leading the health reform and future of medicine it is governed by interest groups and politicians. Do not leave it to "others" to do what needs to be done or we will get the same results, we are those "others" that have to act now to preserve and improve the practice of medicine.

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President's Address

(continued from previous pages)

FSPMR will continue to work in bettering the quality of health care of our patients and promote the right legislative changes that result in an environment that allows our specialty to succeed in those goals. A good example of this effort is our recent call to Florida legislators, with nearly 90 other medical organizations, to expand and strengthen Florida's patient protections to improve access and continuity of care and reduction of red tape and barriers imposed by insurance carriers. Click here and here to see recent letters.

FSPMR annual meeting will be held in conjunction with FAPM annual meeting. This year FSPMR will have a breakout session on Friday afternoon. Click here for more information. I want to thank Dr. Jesse Lipnick and Dr. Andrew Sherman for their work in getting this done.

FSPMR would like to thank our membership for their contributions and those who have volunteer their time and expertise over the past year. As we move forward on a number of health policy fronts at the state and local level, there will be opportunities for further involvement and advocacy. We look forward to our continued joint partnership and efforts to ensure that our specialty is included in these discussions. On behalf of our executive board members and past president we wish to encourage your membership and engagement in the activities of our society. Remember that FSPMR is working for you.

If you are not currently a member, please renew and help us respond to your needs and those of our patients.

We look forward to having you as an active member of your Medical Society and stand ready to respond to your needs.

Sincerely,
Rigoberto Puente-Guzman, MD
President of FSPMR

SAVE THE DATE

June 20-22, 2014

FSPMR Annual Meeting

In conjunction with FAPM

PHYSIATRIST'S VOICE
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Sports Injury Prevention: The Benefits of Stretching on Sprains and Strains in the Youth and Adolescent Population

By: Joshua Rothenberg,D.O.
UM/Jackson Memorial Physical Medicine & Rehabilitation

As the level of organized sporting competition increases in our youth and adolescent population, becoming aware of sports related injuries, and how to prevent them becomes our focus.

Implied in its name, sports injuries are events that occur during athletic events or exercise. Injuries range from sprains and strains to mild traumatic brain injuries, such as concussions. As our equipment and technology advance in the coming decades, many injuries will be able to be prevented. However, a preventive measure that is often neglected may be one of the most basic, inexpensive, and valuable ones: stretching.

Statistics show that 30 million children participate in sports, and of those, 3.5 million injuries occur annually, with a rising trend due to the number of youth that are competing in sports. Children between the ages of 5 and 14 years old account for close to 40% of all sports injuries; with the most frequent injury being sprains and strains.

The statistics also show that contact sports have the highest injury rate, however, that injury is possible in all sports. In some of our most popular sports, greater than 200,000 basketball related injuries, 100,000 baseball/softball related injuries, and 180,000 football related injuries for children between the ages 5-14 years old visited, and were treated in emergency rooms across the United States.

Due to the most common injuries in the youth being sprains and strains, preventative measures being implemented across the country will help to limit this number.

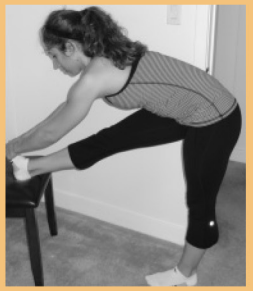
It is not uncommon to see children and adolescents engaging in sporting activities without proper warm up, stretching, or cool down. Jenna Denning, a D.P.T. in Ft. Lauderdale, FL, states, "Children and coaches, alike, are sometimes unaware of the proper stretching techniques and time they should spend stretching prior to and after engaging in athletic competition."

Although recent research has been mixed about the actual benefit of static and dynamic stretching, with some articles favoring and other articles claiming no benefit, there seems to be no detrimental effects of stretching if done correctly.

The benefits that we associate with stretching include increased flexibility, decreased injuries, and improved athletic performance. An important point to note is that stretching should not be considered the "warm up". Stretching stiff and cold muscles could possibly result in injury themselves. Thus, the warm up should occur prior to stretching, which should occur both prior to and after athletic competition. Stretching should be focused on major muscle groups and should be held for approximately 30 seconds. Lastly, stretching should be geared toward the sport being played. For example, runners and soccer players would expect to be using hamstring stretch techniques. It is important to note that stretching can and has resulted in injury if not done properly or appropriately for the sport.

Citations:
1.http://www.hopkinsmedicine.org/healthlibrary/conditions/pediatrics/sports_injury_statistics_90,P02787/
2.http://www.mayoclinic.com/health/stretching/HQ01447/NSECTIONGROUP=2
3. http://www.niams.nih.gov/Health_Info/Sports_Injuries/#ra_2

Jenna Denning, Doctorate of Physical Therapy, demonstrates the appropriate stretching techniques for some of our largest muscle groups in the upper and lower extremities for sprain/strain prevention.



Quadriceps

Calves

Chest

Hamstrings/Back

Hamstrings

Shoulders

PHYSIATRIST'S VOICE
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MARCH WAS BRAIN INJURY AWARENESS MONTH

Wilda Murphy, MD
Medical Director
Shands Rehabilitation Hospital
Gainesville, FL

March was Brain Injury Awareness month. In the US close to 1.7 million people sustain a traumatic brain injury every year. Most of them are able to return to their daily lives activities. However, nearly 125,000 people each year become permanently disabled as a result of their injury.

A Traumatic Brain Injury (TBI) changes a person as an individual and how they interact with the environment. Unlike strokes, tumors or infections, TBI is inflicted by external forces, such as falls, car accidents or sports. Brain damage may result from the primary injury or secondary complications such as swelling or seizures. They experience not only cognitive deficits but also problems with mobility and balance, not to mention related physical injuries. Most patients after TBI do return home and do not require institutionalization. Cognitive and behavioral problems present more challenges to the health care system because they're more difficult to recognize and treat than traditional medical conditions.

TBI can be a life threatening event. Fortunately with the appropriate treatment, people can improve the way their brain functions, and improve their quality of life. Cognitive skills can be relearned with a structured rehabilitation plan of individualized strategies. There are different specialized services offered following the acute care of brain injury treatment. Some brain injury rehabilitation is offered within a Rehabilitation Hospital or other clinical settings such as outpatient rehabilitation. The specific type of rehabilitation depends on the unique needs of the person and the challenges they must overcome. The approach is multidisciplinary and typically includes a Physiatrist, Physical and Occupational Therapy, Speech and Language Pathologist, Recreational Therapy, Psychology, Dietician and Nursing. Persons with TBI need to have a variety of programs available in order to facilitate the continuum of care and optimize their outcomes. Family support is unparalleled.

TBI population is diverse in severity and symptoms. Mild injuries have the best prognosis. Unfortunately severe injuries may lead to tremendous challenges in the realm of mobility, communication and cognition.

Supporting the physical and emotional well being of the person with TBI and the caregiver will ultimately help the whole family in their new roles. Peer support groups may help with community reintegration. Regular exercise can improve mood, cardiovascular fitness and increased self-esteem. Technology is now very accessible and can help compensate for planning and memory difficulties. Psychology treatment may help with coping skills as well as common mood and behavioral issues following TBI such as depression, irritability and cognitive impairment.

Chronic Traumatic Encephalopathy in Athletes from repeated concussions is an area of ongoing research with attempts to identify blood biomarkers that can assist with early detection and treatment.

Traumatic Brain Injury happens in seconds but it may change a life forever.

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Accountable Care Organizations in the US

Jesse Lipnick, MD

I recently had the honor of delivering the address at my local medical society meeting. I spoke about the emergence of Accountable Care Organizations in the United States and in the course of the talk, I discussed the rationale, the challenges and the goals of creating an ACO. If you are not familiar with the concept, an ACO is an organization in which providers accept collective responsibility for the cost and the quality of healthcare for a population of patients. It may or may not contain a hospital or specialty physicians, but it must contain primary care physicians. The goal of an ACO is to simultaneously improve the quality of health and decrease the cost of healthcare for the reference population.

One interesting facet here is the meaning of quality. When we physicians refer to quality, we think about our own skill sets as providers: Did I master enough material to pass my board exams? Do I practice my healing art with enough skill and grace to mend broken people? Do I teach well enough to educate the next generation of physicians? If I am a researcher, do I have the intelligence and the endurance to improve our knowledge of science and medicine? When the government refers to quality, it is discussing something else entirely. The government wants to know if the healthcare system can produce a healthier population at a lower cost. This system measures the skill and the cost of any practitioner in the system against others who deal with the same healthcare issues. In the old fee for service system, a practitioner had to simply show that his skill could heal the sick. In the new fee for value system, the same practitioner must also demonstrate that his service is cost effective relative to others who deal with the same clinical issues. Quality in the future will measure both skill and cost.

Groucho Marx said: All people are born alike, except republicans and democrats and I think he had a point. The responses to my talk varied from one physician comparing an ACO fascsism to another who was hopeful that we could improve quality and decrease cost in the healthcare arena. I was impressed with the divide in the room. One older physician complained that a number of factors in the new system would end the good old days of medicine that we all have come to know and love: We do not know how to type on a keyboard or how to use an electronic medical record. He worried that he would be shunned in the medical community for doing more of the medicine in which he makes his living. He worried that he would be shunned in the medical community for doing more of the medicine in which he makes his living. He worried that the ACO would limit or reject any physician who is relatively expensive compared to others in the same specialty. The new transparency of data only serves to expel those of us who practice medicine in a comprehensive, conscientious and legally safe fashion.

On the other hand, there were a number of physicians present who supported the mission of the ACO. One doctor who trained in Germany could not understand how the USA, so wealthy and powerful could neglect the healthcare of a large proportion of its population. She related that physicians who practice in universal systems still occupy respectable social and financial positions in society. Another hopeful physician noted the opportunity we currently have to foster population heath on par with other developed nations who currently lead the USA in most population health indicators. Unfortunately, the USA lags far behind most developed nations in length of life, infant mortality, cardiac and cerebral vascular events, and many others.

Heraclitus wrote: The only thing that is constant is change. As a community of physicians, we have always been at the forefront of change and we have always figured out how to benefit from it. We have a wonderful common history of innovation and success. I have faith that we can move into our medical future gracefully and that we do have the ability to improve the health of our citizens and to profit in the effort.

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Preventing Prescription Errors

Anthony Menezes, PharmD.

The healthcare industry is more advanced than ever before. New procedures and medications are making great strides to improve the quality of patient care. However, no matter how advanced healthcare has become, medical errors can occur at any point in a patient's care. For instance, before a patient even sees his or her doctor, the staff at the front desk can pull the wrong patient's chart. Large practices might also have multiple patients with the same name. In an effort to save time, a practitioner might pre-write prescriptions for a few patients before entering the exam room, and then mistakenly write a patient's name on the wrong prescription.

With regard to medications, the pharmacy is often the last step before a medication gets into the patient's hands. Therefore it is imperative that medication errors are detected by the pharmacist. Unfortunately, many errors can occur within the pharmacy itself. Numerous errors occur when a pharmacist attempts to decipher a prescriber's handwriting. Rather than calling the clinic, the pharmacist may make an educated guess as to what is written and creates an increased chance of making a filling error. If the error is serious enough, it can cause harm to the patient. Simple errors can occur when a pharmacist is being stretched in too many directions within a pharmacy as well.

Most pharmacies fill several hundred prescriptions in a day. The pharmacist is forced to balance the tasks of answering the phones, typing prescriptions, checking prescriptions, attending the drive-thru window, and using a cash register.

Regardless of the origin of the medication error, an effective way of preventing and catching errors is to increase effective communication between patients, prescribers, and pharmacists. The most important aspect of patient care is the patient. Healthcare professionals should encourage patients to communicate valuable information. Practitioners need vital information such as allergies and health conditions. Also, patients should communicate any other medications they may be taking to the prescriber as well as to the pharmacy. In addition, an accurate medical history may help a prescriber choose the most effective medication to treat a patient. Many errors are also detected when the pharmacist counsels the patient upon dispensing the medication. By asking the right questions, the pharmacist may determine if the appropriate medication is being given, as well as if there are any reasons for concern.

In conclusion, there are many places where errors can occur within the medical system. Healthcare professionals take numerous continuing education courses to prevent them, but perhaps the most effective way of preventing these events may be to improve communication between the individual healthcare providers as well as between the providers and the patients.

DATES TO SAVE

- **FSPMR Annual Meeting in conjunction with FAPM**
  Hyatt Regency Grand Cypress Hotel, Lake Buena Vista
  Orlando FL
  June 20-22, 2014
  Click for More Info and to Register

- **AAPMR Annual Assemble**
  San Diego California
  November 13-16, 2014

- **2014 AANEM 61st Annual Meeting**
  Savannah, GA
  October 29 - November 1, 2014

- **ACRM (American Congress of Rehabilitation Medicine)**
  91st Annual Conference
  Toronto, Canada
  October 7-11, 2014

- **AOCPMR (American Osteopathic College of PM&R)**
  Mid Year Meeting and Scientific Seminar
  Atlantic City, NJ
  April 3-6, 2014.

- **For those interested in interventional pain medicine:**
  FSIPP 2014 Annual Meeiting
  Hilton Orlando Bonnet Creek
  May 15-17, 2014

POINTS OF INTEREST

a. Physician quality reporting and health information technology programs: Medicare eligible professionals who do not meet the requirements for meaningful use by 2015 and in each subsequent year are subject to payment adjustments to their Medicare reimbursements that start at 1% per year, up to a maximum 5% annual adjustment. The programs have been voluntary for the past several years. However, federal laws require Medicare rates eventually to be reduced for physicians who do not participate in the physician quality reporting system as well as the electronic health records and e-prescribing incentive programs.

Participants can benefit from current incentive payments through 2016. In order for eligible physicians and other health professionals to stop a 2015 Medicare EHR noncompliance penalty of 1% in 2015 they must adopt and demonstrate meaningful use of an EHR system by Oct. 1, 2014. The penalty is set to grow to 3% by 2017 for physicians who continue not to participate. Eligible professionals who do not successfully participate in the physician quality reporting system in 2013 will see their Medicare pay reduced by 1.5% in 2015. Failure to report PQRS measures successfully in 2013 will lead to a Medicare penalty of 1.5% on 2015 rates. The reduction will be 2% in 2016 and each subsequent year.

For more information: CLICK HERE

b. 2014 ICD-10 Implementation: The start date is October 1, 2014, the US Department of Health and Human Services (HHS) has mandated the replacement of the ICD-9 code sets used to report medical diagnoses and inpatient procedures to be replaced by ICD-10 code sets. If you have not planned for the conversion now is the time to begin the organization and careful planning for a successful transition. This will require a significant effort and cost to implement. You will need to consider how it will affect your budget, information technology (IT), software, and staff. The transition to ICD-10 is required for everyone covered by the Health Insurance Portability Accountability Act (HIPAA). The change to ICD-10 does not affect CPT coding for outpatient procedures and physician services.

For more information: CLICK HERE

c. 2014 ABPMR subspecialty certification Brain injury medicine (BMI): The new subspecialty, brain injury medicine (BIM), was launched and the examination application period begins on January 1, 2014. The first BIM Examination will be administered on October 6, 2014. The Brain Injury Medicine (BIM) Examination will be offered every other year beginning October 6th, 2014. The examination will be offered again in October of 2016 and 2018. Applications for the 2014 BIM Examination will be accepted from January 1, 2014, through March 15, 2014. From March 16 through March 31, 2014, applications for the BIM Examination will be accepted with a late fee.

d. 2014 New Certification Requirements for Pain Medicine: The ABPMR announces new certification requirements for candidates seeking subspecialty certification in pain medicine. Beginning in 2014, all Pain Medicine Examination candidates must be diplomates in good standing of the ABPMR, ABA, or ABPN and apply for subspecialty certification in pain medicine through their respective boards. Diplomates of other ABMS member boards may apply for subspecialty certification in pain medicine through their board if their board becomes a cosponsor of the Pain Medicine Examination. Diplomates of other ABMS member boards who already hold subspecialty certification in pain medicine through the ABPMR may continue to maintain such certification through the ABPMR even if their primary board is not a cosponsor.

e. 2015 Change in ABPMR subspecialty requirements: Currently, as per ABPMR any subspecialty certificate holder, diplomats, must maintain their primary certification in order to maintain their subspecialty certification, which requires completion of parts I, II, and IV of the Maintenance Certification (MOC) Program along with successfully completing the primary MOC Examination. As of 2015, the ABPMR will no longer require subspecialty certificate holders to maintain primary certification. The subspecialty certificate holders may choose to continue to maintain all certificates (primary and subspecialty) or may maintain only the subspecialty sub-certification(s). They will still have to participate in parts I,II, and IV of the primary MOC program along with successful completion of the subspecialty MOC Examination(s). If diplomates choose to drop their primary certification, they will no longer be certified in that primary specialty area.

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POINTS OF INTEREST

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f. 2014 Primary and Subspecialty Board Deadlines

2014 Examination Dates

Examination	Date of Exam	Location
Primary Certification		
MOC	February 10, 2014	Pearson Professional Centers Nationwide
Part II (oral exam)	May 17-18, 2014	Rochester, MN
Part I (computer-based)	August 25, 2014	Pearson Professional Centers Nationwide
Subspecialties		
Sports Medicine	July 16-19 and Nov 10-15 2014	Prometric Testing Centers Nationwide
Neuromuscular Medicine	August 11-15, 2014	Pearson Professional Centers Nationwide
Hospice and Palliative Medicine	October 2, 2014	Pearson Professional Centers Nationwide
Pain Medicine	September 20, 2014	Pearson Professional Centers Nationwide
Pain Medicine MOC	September 20-October 4, 2014	Pearson Professional Centers Nationwide
Brain Injury Medicine	October 6, 2014	Pearson Professional Centers Nationwide
Pediatric Rehabilitation Medicine & MOC	November 20, 2014	Pearson Professional Centers Nationwide
Spinal Cord Injury Medicine & MOC	November 20, 2014	Pearson Professional Centers Nationwide

Examination Application Timelines

Examination	Applications Available	Applications Due	Late Deadline *(Late fee required)*
Primary Certification			
MOC	August 1, 2013	October 15, 2013	October 31, 2013
Part II	September 15, 2013	November 15, 2013	December 15, 2013
Part I	November 1, 2013	January 31, 2014	February 28, 2014
Subspecialties			
Sports Medicine	December 1, 2013	February 15, 2014	March 1, 2014
Neuromuscular Medicine	December 1, 2013	February 15, 2014	March 1, 2014
Hospice and Palliative Medicine	December 1, 2013	February 15, 2014	March 1, 2014
Pain Medicine & MOC	January 1, 2014	February 28, 2014	March 31, 2014
Brain Injury Medicine	January 1, 2014	March 15, 2014	March 31, 2014
Pediatric Rehabilitation Medicine & MOC	February 1, 2014	March 15, 2014	March 31, 2014
Spinal Cord Injury Medicine & MOC	February 1, 2014	March 15, 2014	March 31, 2014

POINTS OF INTEREST

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g. **Dr. Zipper, who is FSPMR CAC representative and also has the honorable role of being the President of the Florida Association of Pain Medicine (FAPM) has sent out an ALERT for your help:** We have the common goals of pursuing improved quality and access to care, and for that reason we want to help FAPM in this important task. They have hired a public relations firm to bring media attention to issues of patient's access to their needed medications from Pharmacies. To that end, if you have any patients experiencing difficulty with getting their prescriptions filled for Controlled substances please contact Mr. Brian Burgess from Meteoric Media Strategies ASAP at 850-273-2270 or email to brianjburgess@gmail.com. Thank you!

h. Florida law has required physicians to create and maintain a Practitioner Profile [s. 456.041 – 046, Florida Statutes]. Practitioners are required to update their profile within 15 days of any change. Failure to do so places you at risk for disciplinary action. Updating your Practitioner Profile can easily be done using the Florida Board of Medicine's new web page:

- Go to http://www.FLBoardofMedicine.gov
- Click on Resources
- Click on Helpful Links
- Click on Update Your Practitioner Profile

MONTH OF

April

Cancer Control Month: For more information visit the American Cancer Society http://www.cancer.orgv.

National Occupational Therapy Month: For more information visit the American Occupational Therapy Association, Inc. http://www.aota.org.

May

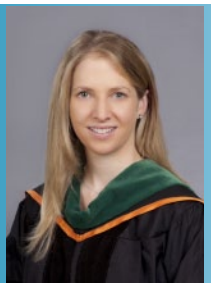
Arthritis Awareness Month: For more information visit the Arthritis Foundation http://www.arthritis.org.

National Osteoporosis Awareness and Prevention Month: For more information visit the National Osteoporosis Foundation http://www.nof.org.

National Trauma Awareness Month: For more information visit the American Trauma Society http://www.amtrauma.org.

National Physical Fitness and Sports Month: For more information visit the President's Council on Physical Fitness and Sports http://www.fitness.gov.

RESIDENTS SECTION



Lauren Lerner, MD
PGY-2 UM PM&R

Spring is an exciting time of year for the residency program of the Department of Physical Medicine and Rehabilitation at the Leonard M. Miller School of Medicine, University of Miami PM&R. After numerous hours of study sessions and formal lectures we took our SAE's (self assessment examinations). We take this exam very seriously as a stepping stone to sitting for our PM&R boards and use the opportunity of the SAE's to identify the areas of our field that we may need improvement in.

Currently we are wrapping up our musculoskeletal ultrasound course and preparing for our OSCE. This examination is proctored by our attendings who act as a patient presenting with a complaint in one of the six major joints: shoulder, elbow, wrist, hip, knee, and ankle. We will be tested on our knowledge of the ultrasound machine, technique, and ability to locate anatomical landmarks.

Our graduating class of seniors will begin the next phase of their successful careers, and we are very proud of them. Three of our graduates will begin pain fellowships this summer at three excellent training programs including the Florida Spine Institute in Clearwater, the Center for Pain Management and Rehabilitation in New Jersey and here at the University of Miami/Jackson Memorial Hospital. One resident will be starting an exciting regenerative medicine fellowship in Colorado and the final two residents will be going straight into general PM&R practice, one in the Fort Lauderdale area and the other in New Jersey. As we wish them the best in their future endeavors, we are also excited to welcome six new members into our PM&R family from another successful match this year!

As we wrap up the year, we are looking forward to welcoming Randall Braddom, MD as our keynote speaker at Research Day on Saturday June 7th, 2014 at 12:30 pm - 4:30 pm as well as the ground-breaking of our brand new nine-story rehabilitation hospital sometime in the near future!

GET INVOLVED
JOIN A COMMITTEE OR VOLUNTEER SOME TIME!

Web Site & Newsletter Committee
Rigoberto Puente-Guzman, MD
Andrew Sherman, MD
Lindsay Shroyer, MD
Bella Chokshi, DO
Jesse A. Lipnick, MD
Katrina Lesher, MD
Wilda Murphy, MD
Quang "Wayne" Nguyen, MD
Lorry S. Davis, MEd (Exec Director)
Stephen Denas (Web Master)

EMG Task Force
Matthew Imfeld, MD
Robert Dehgan, MD
Lindsay Shroyer, MD

If you are interested in helping or joining one of these commttees please contact Lorry Davis at director@fspmr.org

Job Opportunities

For complete details go to: http://www.fspmr.org/jobs.html

Posted 3/18/2014
Seeking Interventional or Outpatient General Practice Opportunity
North Central Florida

Posted 2/18/2014
Seeking Board Certified Physiatrist
Miami, FL

Posted 2/10/2014
High Paying PM&R Coverage Needed
Physical Medicine and Rehabilitation Coverage in Wisconsin

Posted 1/28/2014
Position Offered in East Central Florida
Space Coast area Growing with NASA at the Helm

Posted 01/28/2014
Physiatrist
Tampa , Florida

Call For Patient Education Articles

If you have any pertinent patient education articles and would like to share with our community, please contact Lorry Davis, Executive Director at 352-226-8641, or email at: Lorry4@earthlink.net

JOIN FSPMR

Benefits of membership include:

Meetings with continuing medical education

Opportunity for networking in the state

Email broadcasts keeping you "in the loop," and more frequent email broadcasts during Florida's legislature

A link to organized medicine via representation on the Florida Medical Association's Specialty Society Section

CLICK HERE TO JOIN ONLINE

If you prefere to mail in your application,

CLICK HERE TO DOWNLOAD THE MAIL-IN APPLICATION.