

**APPLICATION FOR PHYSICIANS & SURGEONS AS
EMPLOYED OR INDEPENDENT CONTRACTORS
(Of specified entities)
PROFESSIONAL LIABILITY INSURANCE**

Notice: The policy for which application is made applies only to "Claims" first made during the "Policy Period." The limits of liability shall be reduced by "Claim Expenses" and "Claim Expenses" shall be applied against the deductible. Please read the policy carefully.

If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

1. (a) (i) Full name of Applicant: _____
 (ii) Legal operating name: _____
 (iii) Professional Degree: _____
 (iv) Attach a copy of your letterhead and resume.
- (b) Are you applying for coverage as an independent contractor? Yes No
- (c) Are you applying for coverage as an employed physician? Yes No
- (d) Principal address where services as an Independent contractor or employed physician are to be performed:

 (Street) (City)

 (County) (State) (Zip)
- (e) Name of entity at this location for which coverage as an independent contractor or employed physician is being sought? : _____
 If more than one location, list on separate sheet.
2. Average number of hours you practice each week: _____
3. What is your approximate gross annual income from your practice as an independent contractor or employed physician? \$ _____

II. LICENSE INFORMATION

1. Provide the following information for all of the states in which you practice:

<u>State</u>	<u>License No.</u>	<u>Effective Date</u>	<u>Expiration Date</u>	<u>Active (Yes/No)</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
2. Federal DEA License No. and status: _____

III. EDUCATION AND TRAINING

1. Provide your medical or surgical specialty: _____
2. Are you American Board certified? Yes No
If Yes, what is the Medical specialty in which you are certified: _____
3. Provide the following information:

	<u>Name of Institution</u>	<u>City</u>	<u>State</u>	<u>Date Completed</u>
____ Medical School	_____	_____	_____	_____

IV. SCOPE OF PRACTICE AS INDEPENDENT CONTRACTOR OR EMPLOYED PHYSICIAN

1. (a) Do you perform surgery, other than incision of boils & superficial abscesses or suturing skin & superficial fascia? Yes No
If Yes, complete 1.(b) below.
- (b) If you perform any of the following procedures, check all that apply. For each procedure performed indicate where the procedure is performed: **O** = Office or clinic or **S** = Surgi-center

	<u>Location</u>		<u>Location</u>
<input type="checkbox"/> Abortions	_____	<input type="checkbox"/> Herbal Medicine	_____
<input type="checkbox"/> Acupuncture	_____	<input type="checkbox"/> Homeopathy	_____
<input type="checkbox"/> Adenoidectomy/Tonsillectomy	_____	<input type="checkbox"/> Hyperbaric Medicine	_____
Anesthesia – Non-obstetrical:		<input type="checkbox"/> Hysterectomies	_____
<input type="checkbox"/> General	_____	<input type="checkbox"/> Laser skin resurfacing	_____
<input type="checkbox"/> Spinal	_____	<input type="checkbox"/> Laser Surgery (describe)_____	_____
<input type="checkbox"/> Epidural	_____	<input type="checkbox"/> Lymphangiography	_____
<input type="checkbox"/> Anesthesia – Other (describe)	_____	<input type="checkbox"/> Mesotherapy	_____
_____	_____	<input type="checkbox"/> Minimally invasive surgery (describe)	_____
<input type="checkbox"/> Angiography	_____	_____	_____
<input type="checkbox"/> Angioplasty	_____	<input type="checkbox"/> Myelography	_____
<input type="checkbox"/> Anti-aging procedures – other than use of human growth hormone (describe)_____	_____	<input type="checkbox"/> Needle biopsies (describe)_____	_____
<input type="checkbox"/> Arteriography	_____	<input type="checkbox"/> Obstetrics and Obstetric Care	_____
<input type="checkbox"/> Assisting in Surgery – on own patients or the patients of others	_____	<input type="checkbox"/> Open Reduction of Fractures	_____
<input type="checkbox"/> Bariatrics	_____	<input type="checkbox"/> Osteopathic Manipulation	_____
<input type="checkbox"/> Breast Implants	_____	<input type="checkbox"/> Pain Management (describe)	_____
<input type="checkbox"/> Breast Reductions	_____	_____	_____
<input type="checkbox"/> Catheterization - other than umbilical cord, urethral or arterial line in a peripheral vessel	_____	Plastic Sugery:	
<input type="checkbox"/> Chiropractic Manipulation	_____	<input type="checkbox"/> Silicone implants	_____
<input type="checkbox"/> Cryosurgery - other than on benign or pre-malignant dermatological lesions	_____	<input type="checkbox"/> Silicone injections	_____
<input type="checkbox"/> Chelation Therapy	_____	<input type="checkbox"/> Pneumoencephalography	_____
<input type="checkbox"/> Dermabrasion/Chemical Peels	_____	<input type="checkbox"/> Prolotherapy/proliferative therapy	_____
<input type="checkbox"/> Dilation & Curettage	_____	<input type="checkbox"/> Radiation Therapy	_____
<input type="checkbox"/> Discograms	_____	<input type="checkbox"/> Radiopaque dye injections into blood vessels, lymphatics, sinus tracts or fistulae	_____
<input type="checkbox"/> Electroconvulsive Therapy	_____	<input type="checkbox"/> Refractive surgery: LASIK, PRK, AK, PTK, ICR	_____
<input type="checkbox"/> Erectile Dysfunction Therapy	_____	<input type="checkbox"/> Sex reassignment/sex change surgery	_____
<input type="checkbox"/> Endoscopic procedures	_____	<input type="checkbox"/> Silicone injection	_____
<input type="checkbox"/> Hair Transplants or Suturing of Hairpieces	_____	<input type="checkbox"/> Spinal surgery (incl chemonucleolysis or percutaneous, lumbar discectomy)	_____
		<input type="checkbox"/> Temporomandibular Joint Dysfunction	_____
		<input type="checkbox"/> Trans Myocardial Laser procedures	_____
		<input type="checkbox"/> Weight Reduction	_____
		<input type="checkbox"/> Other (describe): _____	_____

3. Is general anesthesia administered for any of the procedures identified in 1. (a) or (b) above? Yes No
 If Yes, is anesthesia is administered by:
- (a) you? Yes No
 (b) an Anesthesiologist? Yes No
 (c) a Certified Registered Nurse Anesthetist (CRNA)? Yes No
 (i) If Yes, is the CRNA directed by or responsible to an Anesthesiologist?..... Yes No
 (ii) If No, explain the type of surgery and percentage of your surgeries or average number of such cases per month. _____
- (d) Are Harvard Standards for the administration of all anesthesia adhered to?..... Yes No
4. Do you use experimental procedures, devices, drugs or therapy in treatment or surgery? Yes No
5. Do you:
- (a) Dispense prescription drugs?..... Yes No
 If Yes, are you a registered dispensing practitioner?..... Yes No
 (b) Prescribe drugs via the internet?..... Yes No
 If Yes, provide details. _____
- (c) Provide diagnosis via the internet? Yes No
 If Yes, provide details. _____
6. Indicate the number of professional employees you employ or supervise for each of the following:
 (none, check here []) _____
- ____ Physicians other than yourself ____ Podiatrists ____ Chiropractors ____ Optometrists
 ____ Physician's Assistants* ____ Nurses Midwives* ____ Nurse Anesthetists* ____ Psychologists
 ____ Surgeon's Assistants* ____ Nurse Practitioners* ____ Other (describe) _____
- *Provide a description of duties, in detail, including extent supervised on a separate page and attach protocols.
7. Do you anticipate any changes in your work as an independent contractor or employed physician in the next year?
 Yes No
 If Yes, attach a detailed explanation.

VI. AFFILIATIONS

1. Are you in the employ of or under contract to any individual, firm or corporation other than the facility named in I. General Information, 1(e)..... Yes No
 If Yes, provide a detailed explanation including a description of your responsibilities. _____
2. Are you in the employ of or under contract to any governmental entity?..... Yes No
 If Yes, provide a detailed explanation including a description of your responsibilities. _____

VII. CLAIM HISTORY

1. List your prior Professional Liability Insurance for each of the last five (5) years, including the current year:
- | <u>Ins Company</u> | <u>Limits of Liability</u> | <u>Premium</u> | <u>Eff./Exp. Dates</u> | <u>Claims Made or Occurrence Form</u> | <u>Retroactive Date</u> |
|--------------------|----------------------------|----------------|------------------------|---------------------------------------|-------------------------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
2. Has any claim or suit for malpractice ever been made against you? Yes No
 If Yes, how many? _____ Complete a copy of our Supplemental Claim form for each one.

3. Has any claim or suit for malpractice ever been made against you that has not been reported to the current insurer or any prior insurer? Yes No
If Yes, how many? _____ Complete a copy of our Supplemental Claim form for each one.
4. Are you aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit? Yes No
If Yes, how many? _____ Complete a copy of our Supplemental Claim form for each one.
5. Have you ever been investigated, asked to resign or been involved in official or non-official proceedings brought by a hospital, managed care organization or other healthcare organization to deny, limit, suspend, non-renew or revoke your privileges? Yes No
6. Has your license to practice medicine or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state?..... Yes No
7. Have you ever been notified to respond to, appear before or have you ever been investigated by any licensing or regulatory agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct?..... Yes No
8. Have you ever been charged with or convicted of an act committed in violation of any law or ordinance?
..... Yes No
9. Have you ever been evaluated, treated or hospitalized for alcohol or substance abuse or mental or emotional disorders? Yes No

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

No fact, circumstance or situation indicating the probability of a "Claim" or action for which coverage may be afforded by the proposed insurance is now known by any person(s) or organization(s) proposed for this insurance other than that which is disclosed in this application. It is agreed by all concerned that if there is knowledge of any such fact, circumstance or situation, any "Claim" subsequently emanating there from shall be excluded from coverage under the proposed insurance.

Name of Applicant

Signature of Applicant

Title

Date