U.S. Risk *HealthcarePros*

Medical Director's Professional Liability **Application**

U.S. Risk, LLC | 8401 N. Central Expressway, Dallas, Texas 75225

GENERAL INFORMATION

1. Physician Applicant Name: ______
2. Address: ______
   City: ______ State: ______ County: ______ ZIP: ______
3. Phone: ______ Website URL: ______
4. Type of organization, service or facility where applicant provides services as Medical Director:
5. Name of organization: ______
6. Address: ______
   City: ______ State: ______ County: ______ ZIP: ______
7. Phone: ______ Website URL: ______
8. Extent (size) of operations of organization, service or facility, for which these units of exposure are applicable:
   Number of beds: ______ Number of outpatient visits: ______ Number of ambulances: ______
   Organization/service/facility's annual receipts (or operating budget): $ ______
9. Medical Director duties/contract: **Attach copy of contract between Medical Director and organization, including description of the duties and responsibilities of medical director, if not included in contract.**
10. Describe any circumstances wherein the applicant in his/her/their capacity as Medical Director may also be called upon to act with his/her/their capacity as a "physician" to treat, intervene in the treatment, direct the treatment, or consult in the treatment of any person (patient/client):

    How often might such circumstances occur? ______
11. Time commitment: Number of hours per month applicant will provide services as Medical Director: ______
12. Remuneration: Annual remuneration applicant will be paid for service as Medical Director: $ ______
13. **Limit of liability** requested: $ ______ per incident / $ ______ per aggregate
14. **Proposed effective date:** ______ Number of years as Medical Director: ______

APPLICANT PHYSICIAN INFORMATION

15. License number: ______ Expiration date: ______ State: ______ Years licensed: ______
    Certification: ______
16. Current practice: ______ Dates—From: ______ To: ______
    Specialty: ______ Board certified? ☐ Yes ☐ No
    Type of practice: ☐ Solo practice ☐ Partnership ☐ Group practice ☐ Other: ______
    Prior practice: ______ Dates—From: ______ To: ______
17. Medical school: ______ Date completed: ______ Degree: ______
18. Internship/residencies:
    Medical center: ______ Dates served—From: ______ To: ______
    Medical center: ______ Dates served—From: ______ To: ______
19. Hospital privileges (hospital name/address and nature of privileges):

20. Medical Malpractice insurance: **Attach certificate or other verification of current insurance.**

21. Claims information: Has any claim or suit for alleged malpractice been brought against you in the last 5 years, or are you aware of any circumstances that might lead to such a claim/suit? ☐ Yes ☐ No
    If yes, describe event including claimant name, date of incident, suit status, amount of settlement or reserve (or attach separate sheet):

22. Sanctions: Has applicant ever had his/her/their license or certification revoked, suspended, or restricted, or been subject to any disciplinary proceeding, or been reprimanded by an administrative agency, professional association or peer committee? ☐ Yes ☐ No
    If yes, describe in detail:

STATEMENT OF NON-CONFLICT OF RELATIONSHIP

I. Applicant is NOT a principal, proprietor, superintendent, officer director, stockholder or member of the board of directors, trustees, or governors of the organization named in Item 5 of this application, nor is applicant in any other manner, except as Medical Director, affiliated or associated with said organization.

II. No patient or client of the organization named in Item 5 of this application is/will be billed or charged specifically for services afforded by the applicant whether in his/her/their capacity as Medical Director, physician or otherwise.
    Exceptions, if any, to above (absence of entry means "no exceptions"):

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

SIGNATURE PANEL

I/we hereby declare that the statements and particulars in this application are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Applicant signature ______________________ Date ______________________

Typed or printed name: ______________________ Title: ______________________