

# **DOCTORS INSURANCE GROUP**

## **MEDICAL PROFESSIONAL LIABILITY INSURANCE APPLICATION**

With your fully completed, signed and dated application, please submit the following information:

1. Current insurance policy declarations page.
2. Copy of all licenses and board certifications.
3. Currently valued loss runs from all prior insurance companies.
4. Copy of curriculum vitae.
5. Articles of Incorporation, if applicable.

P.O. Box 40457  
Indianapolis, Indiana 46240  
(317) 575-4440 / / (317) 575-4454 (Fax)

**COVERAGE REQUEST**

Requested Effective Date: \_\_\_\_\_  
MONTH DAY YEAR

**A. Limit of Liability: \$250,000 / \$750,000**

B. Please select any optional deductible that you desire. No aggregate limitation will apply to the deductible.

\$10,000  \$15,000  \$20,000  \$25,000  \$50,000  \$100,000  \$200,000  \$250,000

**1. PERSONAL INFORMATION**

Full Name of Applicant: \_\_\_\_\_  MD  DO  \_\_\_\_\_  
FIRST MIDDLE LAST SUFFIX

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
MONTH DAY YEAR

Social Security Number: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Home Address: \_\_\_\_\_  
CITY COUNTY STATE ZIP

**2. OFFICE INFORMATION**

Principal Office Address: \_\_\_\_\_  
CITY COUNTY STATE ZIP

Please check this box if your Principal Office Address is not actually located within the city limits of the city to which your mail is addressed.....

Office Phone Number: ( ) \_\_\_\_\_ Office Fax Number: ( ) \_\_\_\_\_

Secondary Office Locations (if any): \_\_\_\_\_  
CITY COUNTY STATE ZIP

Secondary Office Phone No: ( ) \_\_\_\_\_ Secondary Office Fax Number: ( ) \_\_\_\_\_

Preferred billing address:  Principal Office  Secondary Office  Home

Preferred Contact Person: \_\_\_\_\_ at  Principal Office  Secondary Office

Percentage of practice at each of the above locations: \_\_\_\_\_ Principal Office \_\_\_\_\_ Secondary Office

Email Address(s): \_\_\_\_\_

### 3. EDUCATIONAL INFORMATION

MEDICAL SCHOOLS			
NAME OF MEDICAL SCHOOL(S) ATTENDED	LOCATION OF MEDICAL SCHOOL(S) ATTENDED	DEGREE	DATE GRADUATED

RESIDENCIES, FELLOWSHIPS, AND OTHER POST-GRADUATE TRAINING					
INSTITUTION	HOSPITAL DATA		DATES ( MONTH/YEAR)		COMPLETED?
	LOCATION	SPECIALTY OR DEPARTMENT	START	END	CIRCLE ONE
					YES NO*
					YES NO*
					YES NO*
					YES NO*

\* IF "NO" CIRCLED, EXPLAIN FULLY ON PAGES 15 AND/OR A SEPARATE SHEET

CATEGORY 1 CONTINUING MEDICAL EDUCATION COMPLETED IN PAST THREE YEARS		
COURSES COMPLETED	CME CREDITS RECEIVED	DATE(S) ATTENDED MONTH/YEAR
List all others on page 15		

### 4. PRACTICE HISTORY

PLEASE LIST ALL LOCATIONS WHERE YOU HAVE PRACTICED SINCE RESIDENCY		
LOCATION	DATES ( MONTH/YEAR)*	
	START	END

PROVIDE BRIEF DESCRIPTION OF EACH PRACTICE SITUATION, INCLUDING CLINICAL RESPONSIBILITIES, AND EXPLAIN ANY GAPS IN PRACTICE ON A SEPARATE SHEET.

### 5. LICENSING AND BOARD CERTIFICATIONS

A. Licensing (List all states in which you are currently licensed.)

STATE	LICENSE NUMBER	% OF PRACTICE	WHICH COUNTY?	MEMBER OF STATE MEDICAL ASSOCIATION?
_____	_____	_____	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>
_____	_____	_____	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>

YES  NO

B. If you are a foreign medical school graduate, are you certified by the Education Commission for Foreign Medical Graduates: YES  NO

C. Are you American Board Certified? YES  NO

- i. If "yes," list Specialty Board(s): \_\_\_\_\_ (Indicate allopathic or osteopathic)
- ii. If "yes," list date of initial Board Certification: \_\_\_\_\_
- iii. If applicable, list date of re-certification(s): \_\_\_\_\_
- iv. If "no," are you Board eligible? \_\_\_\_\_ YES  NO
- v. If Board eligible, when do you plan to take your Boards? \_\_\_\_\_

**6. PRACTICE ORGANIZATION**

A. Please check all that apply and provide details. If vicarious liability coverage is desired, so indicate.

- Solo Entity: Name \_\_\_\_\_  
Corp. Tax ID # \_\_\_\_\_ Date of Incorporation \_\_\_\_\_  Coverage Requested
- Member of a partnership or multi-shareholder corporation: \_\_\_\_\_  
Partnership/Group Name \_\_\_\_\_  
Corp. Tax ID # \_\_\_\_\_ Date of Incorporation \_\_\_\_\_  Coverage Requested
- Other – please explain: \_\_\_\_\_  
Entity Name \_\_\_\_\_  
Corp. Tax ID # \_\_\_\_\_ Date of Incorporation \_\_\_\_\_  Coverage Requested

**Please include Articles of Incorporation and any amendments, a list of principals, and a copy of your business letterhead.**

B. Give the full names of all other physicians affiliated with any organization(s) named in Question 6A above.

NAME	CURRENT PROFESSIONAL LIABILITY INSURANCE CO.

**7. HOSPITAL AFFILIATIONS AND PRIVILEGES**

Hospitals where you have, or had, active privileges or where you have applied:

HOSPITAL DATA		DATES (MONTH/YEAR)		% OF YOUR PATIENTS ADMITTED TO THIS FACILITY	ISSUE CERTIFICATE OF INSURANCE? (CIRCLE ONE)	
NAME	MAILING ADDRESS	START	END		YES	NO

**8. INFORMATION ON ALLIED HEALTH CARE PROFESSIONALS**

A. List below any of the following professionals associated with your practice:

**Anesthesia Assistants, Certified Registered Nurse Anesthetists, Cytotechnologists, Emergency Medical Technician, Nurse Practitioners, Nurse Midwives, Optometrists, Perfusionists, Physician Assistants, Psychologists and Surgeon's Assistants.**

Please indicate if coverage is desired for these individuals. A separate application will be required for each individual for whom coverage is requested.

NAME	SPECIALTY	EMPLOYMENT STATUS	TO BE CONSIDERED FOR SHARED LIMITS COVERAGE?
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No

B. Indicate the number of the following types of employees who provide services in your office:

NUMBER	POSITION	NUMBER	POSITION
	Medical Assistant		Nurse (Registered or Licensed Vocational)
	Psychotherapist		Technician (Lab, Pathology, Dialysis, etc.)
	X-Ray Technician		Other

C. Do any of your employees practice at a location geographically separate from yours? YES  NO

If "yes," please explain \_\_\_\_\_

**9. PROFESSIONAL LIABILITY INSURANCE HISTORY**

NAME OF COMPANY (CURRENT)	POLICY LIMITS	PERIOD OF COVERAGE: RETROACTIVE DATE:	<input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCURRENCE
NAME OF COMPANY	POLICY LIMITS	PERIOD OF COVERAGE: RETROACTIVE DATE:	<input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCURRENCE
NAME OF COMPANY	POLICY LIMITS	PERIOD OF COVERAGE: RETROACTIVE DATE:	<input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCURRENCE

A. If you have been insured under a Claims-Made policy, are you requesting that the Company provide prior acts coverage?..... YES  NO

B. If the Company does not offer you prior acts coverage, will you purchase "tail" coverage from your current carrier? If not, please explain on page 15..... YES  NO

C. Has any insurance company (including Lloyds of London) ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? If "yes," please provide complete explanation on page 15..... YES  NO

**Important information regarding questions 9E and 9F (including sub-questions):**

1. The word "claim" as used in Questions 9E and 9F below refers to:
  - a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee or professional corporation or partnership; or
  - b. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you or any partner, associate, employee or professional corporation or partnership.
2. If you answer "yes" to questions 9E through 9F, please complete the attached Supplementary Claims Information Form on page 16 for all such claims.

- D. Have you ever been involved in a malpractice claim or suit, either directly or indirectly? "yes," how many? \_\_\_\_\_ Please provide details for each on page 16. If YES  NO
- E. Other than the claims/suits indicated in 9E, are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit? YES  NO
- i. A request for records from a patient and/or attorney related to an adverse outcome? YES  NO
  - ii. A letter from an attorney regarding your medical treatment of a patient? YES  NO
  - iii. Intra-operative or post-operative complications or other complications resulting in death, paralysis, or other significant disability or the need for follow-up surgery? YES  NO
  - iv. Patient or family member dissatisfaction with the outcome of a procedure, treatment, or diagnosis? YES  NO
  - v. Any other circumstances that might reasonably lead to a claim or suit? YES  NO
  - vi. Have all circumstances that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior professional liability carrier? YES  NO
- a. If Yes, how many? \_\_\_\_\_ Please attach documentation of all such reports.
  - b. If No, please explain on Page 15.

For purposes of this question, check the following box if you are aware of no circumstances that might reasonable lead to a claim or suit.....Not Applicable

**If you answer "yes" to questions 9G through 9P, please provide details on pages 15.**

- F. Has your license to practice medicine or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? YES  NO
- G. Have your hospital staff privileges ever been suspended, revoked, voluntarily surrendered, or in any way restricted? YES  NO
- H. Have you ever failed any licensing or Board Certification examinations? YES  NO   
If yes, how many times? .....
- I. Have you ever been refused hospital privileges? YES  NO

- J. Have you ever appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical or Dental Examiners, or other medical or dental review committee? YES  NO
- K. Have you ever had a patient or a patient representative complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical or Dental Examiners, or other medical or dental review committee? YES  NO
- L. Have you ever been convicted of, pled guilty to or entered into a plea agreement for a violation of any law or ordinance other than traffic offenses, but including driving while under the influence of alcohol or any other substance? YES  NO
- M. Have you ever been evaluated for, recommended for treatment of, diagnosed with, or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any other mental illness, including but not limited to depression and/or chronic fatigue? YES  NO
- N. Have you ever been accused of sexual misconduct of any kind? YES  NO
- O. Do you have any physical handicap or any chronic illness? YES  NO
- P. Have you or your practice been the subject of any billing or reimbursement inquiry or investigation by any governmental agency, private health insurance payors or public health insurance payors, including, but not limited to, Medicare or Medicaid? YES  NO
- If "yes," explain in detail on page 15 including the date(s) and resolution, if any.

## 11. RATING INFORMATION

- A. What is your present specialty? \_\_\_\_\_
- B. What is your present sub-specialty? \_\_\_\_\_
- C. What percentage of your practice is devoted to your specialty? \_\_\_\_\_% Sub-specialty? \_\_\_\_\_%
- D. Have there been any changes in your specialty, or practice activity (including the addition of new procedures) within the past ten years? YES  NO   
If "yes", describe the nature of changes in specialty or practice activities \_\_\_\_\_
- E. Do you anticipate any changes in your specialty, or practice activity (including the addition of new procedures) within the next year? YES  NO   
If "yes", describe the anticipated changes in specialty or practice activities \_\_\_\_\_
- F. Do you perform any procedures not routinely performed by other persons practicing your specialty or subspecialty? YES  NO   
If "yes," please give complete details \_\_\_\_\_
- G. Indicate the average number of: Patients seen per week: \_\_\_\_\_ Hours practiced per week: \_\_\_\_\_
- H. How many hours per week are you on call? \_\_\_\_\_
- I. If applying for obstetrical coverage, indicate:
- Average number of deliveries per year \_\_\_\_\_
  - Percentage of high-risk deliveries \_\_\_\_\_
  - Average number of VBAC deliveries \_\_\_\_\_
  - What induction agents do you use on VBAC patients? \_\_\_\_\_

- e. Do you have privileges to perform C-sections at each hospital you staff? YES  NO
- J. Do you practice Bariatric medicine? YES  NO
- a. If "yes," what drugs do you utilize for weight loss? \_\_\_\_\_
- b. Do you perform Bariatric surgery? YES  NO
- c. If "yes," what percentage of your practice does such surgery constitute? \_\_\_\_\_
- K. Do you now or have you ever provided services to any state, local or federal correctional facility, jail or prison?? YES  NO
- If "yes," please explain: \_\_\_\_\_
- L. Do you treat patients in a nursing home or similar facility? YES  NO
- If "yes," how many patients do you treat there per month, on average? \_\_\_\_\_
- M. Do you serve as a medical director of a hospital, nursing home, or other facility? YES  NO
- If "yes," please provide details: \_\_\_\_\_
- N. Do you, or will you, staff an emergency room? YES  NO
- i. If "yes" how many hours per week? \_\_\_\_\_
- ii. If "yes" in which facilities or for what staffing company: \_\_\_\_\_
- iii. Is this emergency room practice required for staff privileges? YES  NO
- O. Do you render care or perform consultations outside the state of your primary office location, including but not limited to the use of telecommunication technology as a medium for rendering medical services (telemedicine or internet medicine)? YES  NO
- i. If "yes", please indicate all states where you see patients or where the patients being treated reside: \_\_\_\_\_
- ii. What percentage of your total practice does this extra-state activity constitute? \_\_\_\_\_
- P. Do you read or interpret films, slides or specimens of patients who reside in states other than your indicated state of practice? YES  NO
- If "yes", please explain and indicate all states in which the patients reside. Indicate the percentage of your practice corresponding to each such state: \_\_\_\_\_
- Q. Will you read your own X-rays? YES  NO
- a. If "yes", will they subsequently be read by a radiologist? YES  NO
- b. If "yes", within how many hours? \_\_\_\_\_
- R. Do you perform hospital surgical procedures using nurse anesthetists to administer anesthesia who are not directed by/responsible to an anesthesiologist? YES  NO
- If yes, explain the type and volume of such surgeries and the average number of cases per month: \_\_\_\_\_

S. Do you perform surgical procedures at a same day surgery center other than

your office? YES  NO

a. If "yes," what facility? \_\_\_\_\_

b. How many procedures do you perform there annually? \_\_\_\_\_

T. Do you perform surgery in your office or private suite using anesthesia other than local? YES  NO

**If "yes", you must complete the Office Anesthesia Questionnaire in Section 12.**

U. Are you a sports team physician for any college, university, semi-professional or professional team? YES  NO

If yes, please explain: \_\_\_\_\_

V. Do you practice any of the following forms of "Alternative Medicine"?

Ayurvedic Medicine..... YES  NO

Chinese Medicine ..... YES  NO

Homeopathic Medicine ..... YES  NO

Chiropractic Medicine ..... YES  NO

Holistic Medicine ..... YES  NO

Naturopathic Medicine..... YES  NO

If you answered "yes," to any of the above, please describe your practice.  
\_\_\_\_\_

W. Are you employed full-time or part-time by the Federal, State, or Local Government or are you on active military duty? YES  NO

If "yes", explain the nature of your employment and why you desire coverage \_\_\_\_\_

X. Do you, or does any partnership or corporation of which you are a member or shareholder, own or operate a surgery center, medical laboratory, urgent care facility or other medical enterprise other than a physician office practice? YES  NO

If "yes", please provide complete details on page 15. \_\_\_\_\_

If "yes," is access limited to members of your practice?..... YES  NO

Y. Have you entered into any contracts with managed care organizations providing for capitated payments to you for patient care? YES  NO

If "yes", what percentage of your patients fall under such agreements? \_\_\_\_\_

Z. Are you ACLS or ATLS certified? YES  NO

**Please check any of the following that apply to your practice. If none apply, so indicate.**

**Please classify your surgical** | \_\_\_\_\_

**practice, if applicable:**

- Cardiac Surgery
- Cardiovascular Disease
- Colon and Rectal
- General Surgery
- Gynecology
- Hand Surgery
- Head and Neck
- Laryngology
- Neurology
- Obstetrics/Gynecology\*
  - Normal Deliveries\*
  - C-Sections\*
- Ophthalmology
- Orthopedic
  - Spine Surgery
  - No Spine Surgery
- Otology
- Otorhinolaryngology
  - Including elective cosmetic procedures
  - Not including elective cosmetic procedures
- Plastic Surgery
- Rhinology
- Thoracic \_\_\_\_\_%
- Urology
- Vascular \_\_\_\_\_%
- Other \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Abortions
- Acupuncture
- Adenoidectomy
- Anesthesia
  - Spinal
  - Caudal
  - General
  - Local
  - Other \_\_\_\_\_

- Angiography
- Angioplasty
- Appendectomy
- Arteriography
- Arthroscopy
- Assist in Major Surgery
  - On Own Patients
  - On Patients of Others
- Blepharoplasty
- Breast Biopsy
- Breast Implants
  - Cosmetic \_\_\_\_\_% of Practice
  - Reconstructive \_\_\_\_\_% of Practice

Please check any of the following procedures you will perform:

- Breast Reduction
- Cataract Surgery
- Chelation Therapy (for other than heavy metal poisoning)
- Chemonucleolysis
- Cholecystectomy
- Cholecystectomy, Laparoscopic
- Circumcision
- Colonoscopy
- Colposcopy
- Cryosurgery (other than external lesions)
- Dermatological Surgery
  - Botox
  - Chemical peels
  - Chemabrasion
  - Collagen
  - Cryosurgery (Superficial)
  - Dermabrasion
  - Fat Transfer
  - Hair transplants
  - Laser Hair Removal
  - Laser Skin Resurfacing
  - Microdermabrasion
  - Silicone Injections
  - Tumescant Liposuction
  - Other \_\_\_\_\_

- Dermatopathology
- D&C
- Echocardiography
- Encephalography
- Endoscopic Laser Therapy
- Endoscopy other than Proctoscopy, Sigmoidoscopy, Colposcopy and Cystoscopy
- ERCP/ERC
- Exchange transfusions in newborns- How many per year? \_\_\_\_
- Fluoroscopy
- Fracture Reductions
  - Open
  - Closed
- Hemorrhoidectomy
- Hernia Repair
- Hip nailings
- Hyperbaric Medicine
- Hysterectomy
- Infertility Treatment
  - Type \_\_\_\_\_
- Intensive care for newborns within a Tertiary Care Unit
- Laminectomy
- Laparoscopy
- LASIK
- Left Heart Catheterization
- Liposuction
- Lithotripsy
- Mammography
- Myelography
- Myomectomy
- Neonatology

- Norplant Insertion/Extraction
- Organ Transplant
- Osteopathic Manipulative Medicine
- Pain Management
  - Cordotomies
  - Dorsal Root Gangliotomies
  - Facet Blocks
  - Medication Only
  - Nerve Block
  - Pump implantation and removal
  - Rhizotomies
  - Sphenopalatine lesioning
  - Spinal Injections
  - Spinal Cord Stimulators
  - Thoracic Sympathectomies
  - Trigeminal lesioning
  - Other \_\_\_\_\_

- Pedical Screws for Spinal Surgery
- Percutaneous Vertoplasty
- Pacemaker Placement
  - Permanent \_\_\_\_ Temporary \_\_\_\_
- Polypectomy
- Prenatal Care
- Prolotherapy
- Provertin Retinal Therapy
- Radiation/X-ray Therapy
- Radiopaque Dye
- Renal Analysis
- Roux-en-Y
- Sclerotherapy
- Shock Therapy
- Spinal Fusion
- Thyroidectomy
- Tonsillectomy / Adenoidectomy
- Transgender Surgery
- Tubal Ligation
- Vasectomy
- Weight Control
  - % of Practice \_\_\_\_\_
  - Gastric Banding
  - Gastric Bubble
  - Gastric Bypass
  - Gastric Stapling
  - Medications Prescribed:  
\_\_\_\_\_  
\_\_\_\_\_
  - Other \_\_\_\_\_

- None of the above
- Other Procedures (List):  
\_\_\_\_\_

## 12. OFFICE ANESTHESIA QUESTIONNAIRE

If you administer only local anesthesia in your office, you may skip this section and go to page 13. If you administer any anesthesia other than local in your office or private suite, you must complete this section.

### A. Anesthesia Training/Education

- i. Describe your anesthesia training \_\_\_\_\_
- ii. List Continuing Education courses you have taken in the last 5 years that are related to the use of anesthesia in an office setting.  
\_\_\_\_\_
- iii. During the last 5 years, have you participated in an office evaluation program performed by your peers or a risk management organization?..... YES  NO

### B. Methods Utilized

Indicate the types of anesthesia you administer. Also, indicate the number of procedures performed under each type of anesthesia annually as well as the five most commonly performed procedures.

TYPES OF ANESTHESIA		NUMBER OF PROCEDURES	FIVE MOST COMMON PROCEDURES
Minimal Sedation (Anxiolysis)	<input type="checkbox"/> Y <input type="checkbox"/> N		
Moderate Sedation/Analgesia (Conscious Sedation)	<input type="checkbox"/> Y <input type="checkbox"/> N		
Deep Sedation/Analgesia	<input type="checkbox"/> Y <input type="checkbox"/> N		
General Anesthesia	<input type="checkbox"/> Y <input type="checkbox"/> N		

**Minimal Sedation (Anxiolysis)** is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

**Moderate Sedation/Analgesia (Conscious Sedation)** is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

**Deep Sedation/Analgesia** is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

**General Anesthesia** is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

### C. Personnel

- i. Complete the following table concerning others in your office that are involved in patient care related to anesthesia.

NAME	TITLE / SPECIALTY	EMPLOYMENT STATUS	CERTIFICATION
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> ACLS <input type="checkbox"/> BCLS
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> ACLS <input type="checkbox"/> BCLS
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> ACLS <input type="checkbox"/> BCLS
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> ACLS <input type="checkbox"/> BCLS

- ii. If you use contractors, how do you verify insurance, credentials and competency of contracted staff? \_\_\_\_\_

### D. Equipment



- h. How far is it from your office to the nearest hospital? \_\_\_\_\_
- i. Do you have protocols and transfer agreements in place for patients who suffer adverse outcomes or who cannot be discharged home from the office? ..... YES  NO
- j. How does your practice respond to emergencies?
- begin CPR       call 911       have a code team
- all of the above       none of the above
- k. Does your staff conduct practice drills for medical emergencies? .....YES  NO   
If "yes," how many times per year are these drills conducted? \_\_\_\_\_

**G. Post-anesthesia Procedures**

- What is the **minimum** time a patient is monitored following anesthesia? Indicate in minutes and/or hours. \_\_\_\_\_
- Who performs the post-anesthesia monitoring? \_\_\_\_\_
- Does a practitioner qualified in post-anesthesia care remain in the office until the patient is discharged?..... YES  NO   
What are the qualifications of this individual? \_\_\_\_\_
- Do you have established and written discharge criteria for patients receiving anesthesia?..... YES  NO
- If "yes," do all patients meet these criteria prior to discharge?..... YES  NO
- Is this fact documented in the patient's record?..... YES  NO
- Are written discharge instructions provided to the patient or a responsible adult prior to discharge?.....YES  NO

**H. Pediatric Anesthesia**

- Does your practice include pediatric patients?..... YES  NO
- If "yes," what is the youngest patient the practice will treat using anesthesia, other than local? \_\_\_\_\_
- What types of anesthesia (as described in section B above) do you use on pediatric patients? \_\_\_\_\_
- What anesthetic drugs are used on pediatric patients? \_\_\_\_\_
- Is your staff trained in pediatric drug conversions?..... YES  NO
- Is your staff trained to respond to a pediatric emergency?..... YES  NO
- Do transfer agreements include transfer of pediatric patients to appropriate facilities?..... YES  NO

**GENERAL FRAUD WARNING**

**Any person who knowingly includes any false or misleading information on an application for an insurance policy or files a claim containing a false or deceptive statement is guilty of insurance fraud and is subject to criminal and civil penalties.**

**Consent, Warranty, Representations and Acknowledgement of Understanding**

With the submission of this application for insurance, I accept the following conditions during the processing and consideration of my application - regardless of whether or not I am granted insurance - and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release from any and all liability, the Company, its directors, officers, agents, members, employees and other authorized representatives, for any acts pertaining to my application for insurance, including ultimate cancellations, rejection, or approval for insurance, and any communications, reports, records, statements, documents, disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I hereby declare and warrant that the foregoing statements and particulars are, to the best of my knowledge, complete and correct and that I have not deliberately suppressed or misstated any material facts. I understand that this is an application for insurance and is not evidence of coverage.

I acknowledge that acceptance into the Company's insurance program is not a right of every licensed applicant and that my application will be evaluated by authorized personnel. Submission of a payment or deposit with this application and provisional receipt thereof by the Company does not constitute acceptance for insurance nor the creation of an insurance contract. If an applicant is not accepted, any such payment shall be returned to the applicant. I further acknowledge that incomplete or incorrect information could result in retroactive premium adjustment, denial of coverage or voidance of any policy issued in reliance on such information.

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**Applicant's Signature**

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**Date**

## AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance by Midwest Insurance Group, an Risk Retention Group (the "Company") hereby authorizes his present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Company upon its request information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Company may have a bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned also authorizes all medical associations and medical societies in which he is or has been a member, all hospitals in which he now holds or has held staff privileges, any Board of Professional Examiners or Licensure Commission for any state in which he has practiced or resided, and any and all physicians, dentists or any other third party having information regarding the undersigned, to release to the Company upon its request any information that any such person or entity may have which in the judgment of any such person or entity or the Company may have a bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, and the Company, its directors, officers, employees, agents, and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information so provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a copy of this Authorization, which shall be of equal validity with the signed original.

Name (Printed): \_\_\_\_\_

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_



## Supplemental Claims Information

**If there has been more than one claim, please photocopy this form, and complete a separate form for each. Attach additional sheets if needed for adequate explanation. All questions must be answered or marked Not Applicable (N/A).**

1. Patient's name: \_\_\_\_\_

2. Date reported to insurance company: \_\_\_\_\_

3. Name of Insurance Company: \_\_\_\_\_

4. Date of incident and your treatment: \_\_\_\_\_

5. Allegations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. What is the present condition of the patient? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? YES  NO

8. Status of claim (check applicable answer):

Suit threatened, no action taken

Suit filed but dropped by claimant

Summary Judgment in your favor

Court outcome in your favor

Jury Verdict

Directed Verdict

Suit settled Out-of-Court

a. Date claim paid \_\_\_\_\_

b. Amount paid \_\_\_\_\_

c. Did you want to settle this claim? YES  NO

Court Outcome in favor of plaintiff

Jury Verdict

Directed Verdict

Amount of Loss Payment: \$ \_\_\_\_\_

Awaiting mediation

Awaiting court action

a. Reserve amount:

\$ \_\_\_\_\_

9. Name and address of the attorney assigned to your case: \_\_\_\_\_

\_\_\_\_\_

10. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? YES  NO

If "yes", amount was \$ \_\_\_\_\_.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (Printed): \_\_\_\_\_