# NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA

# Psychiatrists Professional Liability Insurance

# ILLINOIS

# application

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| --- |
| **If CLAIMS MADE COVERAGE is chosen, READ THE FOLLOWING NOTICE:**  **NOTICE: Coverage is limited to liability for claims first made against YOU during the policy period or anY extended reporting period, if applicable. Please review the policy carefully and discuss the policy with your insurance representative.**  **INSTRUCTIONS:**   * Carefully review and fully answer each of the following questions completely. * Continue with completion of the application and return it along with a copy of your most recent certificate of insurance or declarations page and a claims history report from the carrier. * Complete the application in its entirety. Do not leave any question unanswered. If any question does not apply to you, state N/A. Please use a separate sheet of paper for any additional information, explanation or clarification.   **ALL APPLICATIONS ARE SUBJECT TO UNDERWRITING APPROVAL.**  **This is only an application. No coverage exists until a policy is issued in your name.** |

# GENERAL INFORMATION: (Please type or print)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Applicant Name: | | |  | |  | | | |  | | | | |  | | | |
|  | | | First | | Middle | | | | Last | | | | | (MD or DO) | | | |
| Mailing Address: | | |  | | | | | | | | |  | | | | | |
|  | | | Street | | | | | | | | | City/State/Zip | | | | | |
| Phone: |  | | | Fax: | | |  | | | |  | | E-Mail: | | |  | |
| 1. Current Medical Licenses: Please provide the following information for all of the states in which you are licensed. | | | | | | | | | | | | | | | | | |
|  | | State | | | | License No. | | | | Effective Date | | | | | Expiration Date | | Active (Yes/No) |
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| List All Active Professional Association Memberships: | | | | | | | |  | | | | | |  | | | |
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# B. EDUCATION AND TRAINING

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Name and location of Medical School granting Degree | | | | | | | | | | | | | | | | | | |
| School’s Name:  Graduation Date: | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
| If you are a graduate of a non-US medical school, have you obtained an ECFMG Certificate? | | | | | | | | | | | | | | 🞎 Yes | | 🞎 No | | |
|  | | | | | | | | | | | | | | | | | | |
| 1. Are you Board Certified by the American Board of Psychiatry & Neurology or the Royal College of Physicians and Surgeons in any of the following specialties? | | | | | | | | | | | | | | | | | | |
| 🞎 Yes | | | | 🞎 No | | | | General Psychiatry | | | Date Attained: | | \_\_\_/\_\_\_/\_\_\_\_ | | Last Renewal: | | \_\_\_/\_\_\_/\_\_\_\_ | |
| 🞎 Yes | | | | 🞎 No | | | | Child & Adolescent Psychiatry | | |  | | \_\_\_/\_\_\_/\_\_\_\_ | | Last Renewal: | | \_\_\_/\_\_\_/\_\_\_\_ | |
| 🞎 Yes | | | | 🞎 No | | | | Geriatric Psychiatry | | |  | | \_\_\_/\_\_\_/\_\_\_\_ | | Last Renewal: | | \_\_\_/\_\_\_/\_\_\_\_ | |
| 🞎 Yes | | | | 🞎 No | | | | Other (Specify) |  | |  | | \_\_\_/\_\_\_/\_\_\_\_ | | Last Renewal: | | \_\_\_/\_\_\_/\_\_\_\_ | |
|  | | | | | | | | | | | | | | | | | | |
| 1. Residency: List all resident training and locations. If more than one specialty was completed, please enter each specific specialty. | | | | | | | | | | | | | | | | | | | |
|  | Specialty Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ From: \_\_\_/\_\_\_/\_\_\_\_ To: \_\_\_/\_\_\_/\_\_\_\_ Completed? 🞎 Yes 🞎 No | | | | | | | | | | | | | | | | | | |
|  | Name of Hospital/Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
|  | City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
|  |  | | | | | |  | | |  | |  | | | | | |
|  | Specialty Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ From: \_\_\_/\_\_\_/\_\_\_\_ To: \_\_\_/\_\_\_/\_\_\_\_ Completed? 🞎 Yes 🞎 No | | | | | | | | | | | | | | | | | | |
|  | Name of Hospital/Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
|  | City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| 1. Have you participated in any additional training? (i.e., Fellowship, etc.) | | | | | | | | | | | | | | | | | | | |
|  | | Specialty Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ From: \_\_\_/\_\_\_/\_\_\_\_ To: \_\_\_/\_\_\_/\_\_\_\_ Completed? 🞎 Yes 🞎 No | | | | | | | | | | | | | | | | | |
|  | | Name of Hospital/Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | |
|  | | City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | |
|  | | Specialty Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ From: \_\_\_/\_\_\_/\_\_\_\_ To: \_\_\_/\_\_\_/\_\_\_\_ Completed? 🞎 Yes 🞎 No | | | | | | | | | | | | | | | | | |
|  | | Name of Hospital/Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | |
|  | | City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | |
|  | | | |  | | | |  |  | |  | |  | | | | | |
| 1. Have you successfully completed psychoanalytic training? | | | | | | | | | | | | | | | | | | |
| 🞎 Yes | | | | 🞎 No | | | |  |  | | Date Attained: | | \_\_\_/\_\_\_/\_\_\_\_ | | | | | |
| **If Yes:** | | | |  | | | |  |  | |  | |  | | | | | |
|  | | | | Average weekly # of **total practice** hours: | | | | | | |  | |  | | | | | |
|  | | | | Average weekly # of **psychoanalytic** hours: | | | | | | |  | |  | | | | | |
|  | | | | Average weekly # of **psychoanalytic** patients: | | | | | | |  | |  | | | | | |
| 1. Have you participated in any Risk Management Seminar(s) during the last 12 months for which you earned at least 4 CME credits? | | | | | | | | | | | | | | | | | | |
| 🞎 Yes | | | 🞎 No | | **If Yes**, please attach a copy of the certification for the seminar.  Additionally, how many hours in the past 12 months:\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |

# C. INSURANCE AND PROFESSIONAL HISTORY

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 🞎 Yes | 🞎 No | Have you ever been denied professional liability insurance coverage?NOTE: MISSOURI APPLICANTS DO NOT RESPONDIf Yes, please attach a separate sheet containing a complete explanation. | | | | |
| 🞎 Yes | 🞎 No | Has your professional liability insurance coverage ever been cancelled or refused renewal? **NOTE: MISSOURI APPLICANTS DO NOT RESPOND** If Yes, please attach a copy of the cancellation or non-renewal notice or letter. | | | | |
| 🞎 Yes | 🞎 No | Has your application (new or renewal) for professional liability insurance coverage ever been accepted subject to any conditions or restrictions? If Yes, please attach a separate sheet containing a complete explanation. | | | | |
|  | |  | |  |  | |
| Prior Insurance: List insurers or your employers’ insurers in the past ten (10) years. Attach a copy of your most recent declaration page. Explain any uninsured periods. Attach additional pages as needed. | | | | | | |
|  | | |  |  |  | |
| Insurance Carrier | | | Coverage Dates | Limits of Liability | Coverage Type (Occurrence/Claims-Made) | Claims-MadeRetroactive Date |
|  | | |  |  |  |  |
|  | | |  |  |  |  |
|  | | |  |  |  |  |
|  | | |  |  |  | |
| Practice Locations: List ALL locations at which you have practiced in the last ten (10) years. Explain any periods in which you did not practice.Attach additional pages as needed. | | | | | | |
| (a) Name of Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ From: \_\_\_/\_\_\_/\_\_\_\_ To: \_\_\_/\_\_\_/\_\_\_\_ | | | | | | | |
| City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| (b) Name of Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ From: \_\_\_/\_\_\_/\_\_\_\_ To: \_\_\_/\_\_\_/\_\_\_\_ | | | | | | | |
| City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| (c) Name of Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ From: \_\_\_/\_\_\_/\_\_\_\_ To: \_\_\_/\_\_\_/\_\_\_\_ | | | | | | | |
| City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |

# D. COVERAGE REQUEST

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Desired Effective Date of Coverage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***NOTE: The earliest effective date we can grant, if your application is approved, is the postmark date of your submission.*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | |  | |  | | | | | | | | |  | | | | | | | | | | |
| 1. **Type of Coverage:** | | | | |  | |  | | | | | | | | |  | | | | | | | | | | |
| 🞎Claims-Made (All states)  **Requested Retroactive Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | * Claims-Made w/Prepaid Tail   (**May not be available in all states**) | | | | | | | | | * Occurrence   (**May not be available in all states**) | | | | | | | | |
| If prior coverage was on a claims-made policy, was the Extended Reporting Period Endorsement Purchased? 🞎 Yes 🞎 No (If yes, please attach a copy.) **Kansas Healthcare Providers ONLY**: Number of Kansas Health Care Stabilization Fund Years of Compliance \_\_\_\_\_\_\_\_\_\_\_\_  Percentage of Annual Kansas Professional Practice \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Kansas Healthcare Stabilization Fund Coverage Limits (check one):  $100,000/$300,000  $300,000/$900,000  $800,000/$2,400,000 | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | | | | |  | | | | | | | |  | | | | | | | | |
| 1. **Limits of Liability: (Professional)** | | | | **(Additional Underwriting Guidelines may apply to selected Limits of Liability; All limits of Liability may not be available in all states.)** | | | | | | | | | | | | | | | | | | | | | | |
| $100,000/$300,000 (LA – REQUIRED LIMIT) | | | | | | | | | | | | $1,000,000/$3,000,000 | | | | | | | | | | | | | | |
| $200,000/$600,000 | | | | | | | | | | | | $1,300,000/$3,900,000 (NY ONLY) | | | | | | | | | | | | | | |
| $250,000/$750,000 | | | | | | | | | | | | $2,000,000/$6,000,000 (VA Residents will receive the current state minimum) | | | | | | | | | | | | | | |
| $500,000/$1,500,000 (PA – REQUIRED LIMIT) | | | | | | | | | | | | OTHER $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| 1. **Limits of Liability: (Premises)** 2. **Deductible:**  Please indicate the requested deductible amount. | | | | | | | | | | | | $10,000/$10,000 | | | | | | | | $1,000,000/$1,000,000 | | | | | | |
| 🞎 None | | | 🞎 $5,000 | | | | | | | | | | 🞎 $10,000 | | | | | | | | | | 🞎 $15,000 | | | |
|  | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| **5. Please select your desired coverage sub limits for the below coverage’s:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Your policy may already provide lower limits of these coverage’s at no charge* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Corporate Identity Protection:** | | | **Billing E&O Claim Expense** | | | | | | | | | | **HIPPA Defense Coverage** | | | | | | | | | | **Administrative Hearing Defense** | | | |
| $100,000 | | | $50,000 | | | | | | | | | | $100,000 | | | | | | | | | | $50,000 | | | |
| $250,000 | | | $100,000 | | | | | | | | | |  | | | | | | | | | | $100,000 | | | |
|  | | |  | | | | | | | | | |  | | | | | | | | | | $250,000 | | | |
|  | | |  | | | | | | | | | |  | | | | | | | | | | $500,000 | | | |
| **6. Type of Practice:** | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| 🞎 General Psychiatry | | | | | | | | | | | | 🞎 Other Psychiatric Specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| 🞎 Neuropsychiatry | | | | | | | | | | | |
| 🞎 Child & Adolescent Psychiatry | | | | | | | | | | | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **7. Residents, Fellows, and Early Career Psychiatrists:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 🞎 Residents and Fellows coverage for “moonlighting” practice confined to psychiatry and totaling 20 hours or less per week. (Must be in an ACGME or RCPS(C) approved Residency/Fellowship Training Program full time and in PGY2 or later.) | | | | | | | | | | | | | | Training Program/School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Expected Residency/Fellowship Completion Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| 🞎 First, second or third year of practice following completion of residency or fellowship: **Beginning Practice Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | Residency Completed Date (M/D/Y): \_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Fellowship Completed Date (M/D/Y): \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_ | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| * First, second or third year of practice following discharge from active duty in the military: **Beginning Practice Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | Discharge Date (M/D/Y): \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | |
| **8. Additional Coverage requested*: If you check any of these boxes, please complete the Supplement for Practice Structure/Vicarious Liability Coverage. Coverage for your entity will not be provided without this additional supplement.*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * Employer of other Professionals * Contractor of the services of other Professionals | | | | | | | | | * Incorporated Solo Private Practice * Professional Corporation with more than one shareholder | | | | | | | | | | | | | * Professional Partnership/Association * Fictitious Name Entity or DBA * Joint Venture or LLC | | | | |
| **9. Do you employ any of the following professionals?** *If yes, please follow additional instructions.* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * Nurse Practitioner | | * Registered Nurse | | | | | | | | | * Psychologist | | | | * Counselor | | | | | | * Other (specify) | | | | | |
| *Please indicate if coverage is needed below* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * Yes | * No | * Yes | | | | * No | | | | | * Yes | | * No | | * Yes | | | | * No | | | | | * Yes | * No | |
| ***Please indicate the number of individuals employed below(include those who do not need coverage – a separate application is required for coverage)*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | |  | | | |  | | | | | | | | |  | | |
| **10. Do you need coverage for your duties as a medical director?** *Please indicate additional information required below* | | | | | | | | | | | | | | | | | | | | | | | | 🞎 Yes | 🞎 No | |

# CURRENT PRACTICE LOCATIONS:

# *Please complete a section for each location at which you are currently practicing (Please list principal location first). Include current practice locations covered by another carrier. Copy this page for additional locations as needed.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. Entity Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **This location is a:** | |  | |
| Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 🞎 Private Office | | 🞎 Admitting Hospital | |
| City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 🞎 Nursing Home | | * Non-Admitting Hospital   If non-admitting, please explain: | |
| County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 🞎 Office in the Home | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | * Detention Facility   (Jail, Prison, Home for Juveniles, half-way houses for those convicted of or awaiting trial or criminal charges, or institutions for the treatment and confinement of those found “not guilty by reason of insanity”, “guilty but mentally ill”, etc.) | | * Outpatient Clinic * Government Hospital (Federal, State, Local) * Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Beginning Date of Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Average weekly practice: (in hours):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Average number of patients per week:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | |  | | | |
| 1. Is coverage desired for your work at this location? **If your practice activities at this location will be covered by another professional liability insurance carrier, please provide the name of the carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | 🞎 Yes | | 🞎 No |
|  | | |  | |  |
| 1. Do you serve as the Medical Director or Chief of Psychiatry at this location? | | | 🞎 Yes | | 🞎 No |
|  | | |  | |  |
| 1. If this is a hospital or institution, is it accredited by a nationally recognized accreditation organization? | | | 🞎 Yes | | 🞎 No |
|  | | |  | |  |
| 1. If this is a hospital or institution, has it ever lost accreditation awarded by a nationally recognized accreditation organization? | | | 🞎 Yes | | 🞎 No |
|  | | |  | |  |
| 1. Do you teach at this location? | | | 🞎 Yes | | 🞎 No |
| 🞎 Classroom Teaching | 🞎 Clinical Teaching | Average number of weekly hours spent clinical teaching: | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. Entity Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **This location is a:** | |  | |
| Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 🞎 Private Office | | 🞎 Admitting Hospital | |
| City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 🞎 Nursing Home | | 🞎 Non-Admitting Hospital (please explain): | |
| County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 🞎 Office in the Home | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | * Detention Facility   (Jail, Prison, Home for Juveniles, half-way houses for those convicted of or awaiting trial or criminal charges, or institutions for the treatment and confinement of those found “not guilty by reason of insanity”, “guilty but mentally ill”, etc.) | | * Outpatient Clinic * Government Hospital (Federal, State, Local) * Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Beginning Date of Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Average weekly practice: (in hours):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Average number of patients per week:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | | |  | |  |
| 1. Is coverage desired for your work at this location? **If your practice activities at this location will be covered by another professional liability insurance carrier, please provide the name of the carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | 🞎 Yes | | 🞎 No |
|  | | |  | |  |
| b) Do you serve as the Medical Director or Chief of Psychiatry at this location? | | | 🞎 Yes | | 🞎 No |
|  | | |  | |  |
| 1. If this is a hospital or institution, is it accredited by a nationally recognized accreditation organization? | | | 🞎 Yes | | 🞎 No |
|  | | |  | |  |
| 1. If this is a hospital or institution, has it ever lost accreditation awarded by a nationally recognized accreditation organization? | | | 🞎 Yes | | 🞎 No |
|  | | |  | |  |
| 1. Do you teach at this locations? |  |  | 🞎 Yes | | 🞎 No |
| 🞎 Classroom Teaching | 🞎 Clinical Teaching | Average number of weekly hours spent clinical teaching: | | | |

# F. PRACTICE PROFILE: Please attach a separate sheet for any required explanations.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. Do you sign insurance or other reimbursement forms for patients where you have not participated in their care and treatment? **If yes**, please describe in what capacity (e.g., as a Medical Director) and indicate if you clarify what your signature means on such forms.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | 🞎 Yes | 🞎 No | |
| 1. Do you practice as a medical director?   **If yes,** type and name of facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Briefly describe your responsibilities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please be sure to include this location in Section E. Current Practice Locations of the Application. | | | | 🞎 Yes | 🞎 No | |
| 1. Do you have admitting privileges? **If yes,** make sure the hospital is listed in Section E. Current Practice Locations of the Application. **If no**, please describe your mechanism for handling your patients who may require immediate in-patient care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | 🞎 Yes | 🞎 No | |
| 1. Do you create and maintain a psychiatric/medical record for each patient under your care?   **If no**, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | 🞎 Yes | 🞎 No | |
| 1. Do you prescribe controlled substances? | | | | 🞎 Yes | 🞎 No | |
| 1. Do you obtain an informed consent, whether signed by patient or noted in chart, before prescribing, especially when prescribing neuroleptics? | | | | 🞎 Yes | 🞎 No | |
| 1. Do you have patients sign an arbitration agreement?   **If yes**, is signing a condition of treatment? | | | | 🞎 Yes  🞎 Yes | 🞎 No  🞎 No | |
| 1. Do you write prescriptions for patients you have not clinically evaluated **other than to cover for another colleague** whose patient requires a minimal refill on an existing prescription?   **If yes**, please explain under what circumstances:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | 🞎 Yes | 🞎 No | |
| 1. Do you provide medication management for patients who see another professional (e.g., Ph.D., MSW) as their primary therapist and see you for medication management only?   For how many patients per week? \_\_\_\_\_\_\_\_\_ How often do you see each patient? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | 🞎 Yes | 🞎 No | |
| 1. Do you regularly treat general medical conditions presented by your psychiatric patients? **If yes**, please indicate: | | | | 🞎 Yes | 🞎 No | |
| * Average number of patients per week you provide general medical treatment to: \_\_\_\_\_\_\_\_\_\_\_\_ * Nature of the conditions you treat and the type of treatment you provide: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  |  | |
| 1. Do you specialize in Child and Adolescent Psychiatry?   **If yes**, and have successfully completed a two (2) year ACGME or RCPS(C)-approved fellowship in Child/Adolescent Psychiatry please provide the completion date: (M/D/Y): \_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  State what percentage of your total patient load during the previous policy year were child & adolescent patients \_\_\_\_\_\_%  State what percentage of your total patient load for the upcoming policy year is anticipated to be child & adolescent patients \_\_\_\_\_\_% | | | | 🞎 Yes | 🞎 No | |
| 1. Do you now practice any specialty other than psychiatry?   **If yes**, check applicable specialty(ies) below and indicate % of practice: | | | | 🞎 Yes | 🞎 No | |
| 🞎 General Practice % | | 🞎 Pediatrics % | |  |  | |
| 🞎 Family Practice % | | 🞎 Other (Specify) % | |  |  | |
| 1. Have you ever practiced a specialty other than psychiatry?   **If yes**, what specialty?                           From: \_\_\_/\_\_\_/\_\_\_\_ To: \_\_\_/\_\_\_/\_\_\_\_ | | | | 🞎 Yes | 🞎 No | |
| 1. Do you advertise as a **specialist**\* in the evaluation and treatment of any of the following? | | | | 🞎 Yes | 🞎 No | |
| 🞎 Borderline Personality Disorder | 🞎 Chronic Pain | | 🞎 Multiple Personality Disorder or Dissociative Disorders |  |  | |
| 🞎 Childhood Sexual Abuse | 🞎 Eating Disorders | | 🞎 Sex Therapy |  |  | |
| If yes, how many patients for each specialty?      What percentage of your total patient load?  ***\*Note: “Specialist” is indicated by 1) advertisements, 2) marketing materials, 3) letterhead, or 4) employment, contractual relationship or admitting privileges at any institution with a special interest in any of the above.*** | | | |  |  | |
| 1. Do you supervise any other psychiatrist or other mental health care providers specializing in the disorders/activities listed in #14? | | | | 🞎 Yes | 🞎 No | |
| 1. Does your treatment include use of abreaction, rage, sodium amytal, sex, antiandrogen or recovered memory therapies? **If yes**, please explain the clinical details regarding this treatment. | | | | 🞎 Yes | 🞎 No | |
| 1. Does your practice include forensic activities, e.g., child custody and visitation; criminal responsibility; competence, civil and criminal; correctional psychiatry; juvenile justice and violence? | | | | 🞎 Yes | 🞎 No | |
| * State the percent of your total practice time devoted to this activity. * On a separate sheet, please explain the exact type of forensic activities. | | | | % |  | |
| 1. Do you communicate with patients via e-mail? | | | | 🞎 Yes | 🞎 No | |
| * State the percent of your total patient load that you communicate with by email. * Do you utilize e-mail to render psychiatric services? * Do the patients reside in a state other than the state in which you are licensed to practice? If yes, please explain. * Do you obtain informed consent regarding at least confidentiality/privacy issues involved with email communication, the topics generally not appropriate for email, and the risks and benefits including possible clinical limitations when using email? * On a separate sheet, please explain the nature of communications in detail. | | | | %   * Yes * Yes * Yes | 🞎 No  🞎 No  🞎 No | |
|  | | | |  | |  | |
| 1. Does your practice include telemedicine activities, e.g., direct interaction with patients through electronic means (video, computer, or telephone) in order to provide healthcare to patients who are geographically separated from the clinicians involved? | | | | 🞎 Yes | | 🞎 No | |
| **If yes:**   1. State the percent of your total practice time devoted to this activity. 2. While being treated, are the patients physically located outside the state or jurisdiction where your practice is located?    1. If yes, are you currently licensed to practice in the state or jurisdiction where the patient is located at the time of treatment?    2. Is the jurisdiction outside the U.S.? 3. On a separate sheet, please explain the details of the telemedicine arrangement (i.e. the location, equipment, conditions being treated, number of patients, mental health professionals and/or other resources available to the patient at his/her location, etc.) | | | | %   * Yes * Yes * Yes | | * No * No * No | |
| 1. Do you engage in any clinical and/or pharmaceutical research or research involving medical devices? | | | | * Yes | | * No | |
| **If yes,** please complete the Clinical/Pharmaceutical Research Supplement and submit it along with a copy of the indemnification agreement provided by each pharmaceutical company. | | | |  | |  | |
| 1. Do you treat patients with unconventional therapy, i.e., treatment not considered to be mainstream psychiatric treatment?   **If yes**, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  | |  | |
| 1. Do you have a website, or are you affiliated with a website?   **Website address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | 🞎 Yes | | 🞎 No | |
| 1. Does your practice include the use of narcotic drugs for opioid addiction treatment?   **If yes**, please provide proof of special DEA registration or of a DATA 2000 waiver. | | | | 🞎 Yes | | 🞎 No | |
| 1. Do you perform Brain Spect Imaging?   **If yes**, please describe your weekly patient volume and training related to this procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | 🞎 Yes | | 🞎 No | |
| 1. Do you perform Vagus Nerve Stimulation therapy (VNS)?   **If yes:**   1. Please provide evidence of your completion of training for the use of VNS Therapy. If the training program   is one that ***was not*** sponsored by Cyberonics, please include a brochure detailing the program.   1. Please provide an example of the informed consent form and any other materials that will be used as part of the   informed consent process with patients for VNS therapy.   1. On a separate sheet of paper, please describe:    1. your methods of monitoring patients using VNS therapy    2. how you will determine which of your referral physicians are qualified and trained to perform the surgical procedure for implantation of the VNS pulse generator 2. Will VNS therapy be prescribed for an off-label use? | | | | 🞎 Yes  🞎 Yes | | 🞎 No  🞎 No | |
| 1. Do you perform Electroconvulsive Therapy (ECT)?   **If yes:**    a) Do you comply with the American Psychiatric Association (APA) recommendations for team members participating in ECT treatment to include: ECT privileged psychiatrist, an anesthesia provider, recovery nurse, treatment nurse or assistant in ECT room? If not, please describe on a separate sheet of paper the team in place for ECT.  b) Do you comply witth APA recommendations for having the appropriate equipment available for administering ECT and in the recovery area? If not, please discuss on a separate sheet of paper the equipment not available to you.  c) Do you follow specific criteria for when inpatient ECT is administered as opposed to on an outpatient basis?  d) Do you document in the medical record pre-treatment evaluation and medical history, indications for administering ECT, informed consent, monitoring during ECT and the recovery phase, response to treatment and plan of care?  If not, please discuss on a separate sheet of paper. | | | | 🞎 Yes  🞎 Yes  🞎 Yes  🞎 Yes  🞎 Yes | | 🞎 No  🞎 No  🞎 No  🞎 No  🞎 No | |
| 1. Will you be performing any activities which will be covered by another professional liability policy?   **If yes,** check the following: 🞎 Employee 🞎 Independent Contractor 🞎 Resident/Fellow 🞎 Faculty  Please be sure to list the practice location in Section E. Current Practice Locations of the application. | | | | 🞎 Yes | | 🞎 No | |
| 1. Do you have EACH of the following in place?   (a) (a) a person or group responsible for information security  (b) a virus protection program  (c) a firewall  (d) a software update process, including updating patches and anti-virus software   1. Has Applicant experienced any loss related to personal identity in the past 3 years?   If yes, include date, type and amount of loss: ­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | 🞎 Yes  🞎 Yes  🞎 Yes  🞎 Yes  🞎 Yes | | 🞎 No  🞎 No 🞎 No  🞎 No  🞎 No | |

# G. Professional Liability Profile

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|  |  |  | |
| ***If you answer “YES” to any question,***  ***please provide a detailed written explanation and attach copies of all pertinent official documentation.*** | | | |
|  |  | |  |
| Yes | No | | Has your license to practice medicine been denied, revoked, suspended, voluntarily surrendered or not renewed, reprimanded, fined, or subjected to probationary terms? |
|  |  | |  |
| Yes | No | | Has your license to prescribe controlled substances been denied, revoked, suspended, voluntarily surrendered or not renewed, reprimanded, fined, or subjected to probationary terms? |
|  |  | |  |
| Yes | No | | Have you been previously or currently diagnosed with any physical or mental condition that impairs or could impair your ability to practice medicine? |
|  |  | |  |
| Yes | No | | Have you ever been denied a specialty board certification or re-certification? |
|  |  | |  |
| Yes | No | | Have you ever experienced any dependency upon or been treated for alcohol, narcotics, or other drugs? |
|  |  | |  |
| Yes | No | | Have you ever had hospital privileges denied, suspended, or subjected to conditions and restrictions? |
|  |  | |  |
| Yes | No | | Have you been the subject of an investigation or disciplinary proceedings by any governmental agency (e.g., State Medical Board, DEA, HHS), professional society (e.g., APA or its District Branches) or a professional review board of a hospital, HMO, PPO, or IPA? Or, are you aware of any incident that could lead to such action?  **If yes**, please complete the Claims History Supplement and provide copies of the charging documents and orders in those proceedings. |
|  |  | |  |
| Yes | No | | Have you been charged with, convicted of, or pleaded guilty or no contest to a felony? |
|  |  | |  |
| Yes | No | | Have you ever been, or are you currently sexually or romantically involved with any current or former patient or with a key third party of a patient? (Key third parties include, but are not limited to, spouses or partners, parents, guardians, surrogates, and the like.) |
|  |  | |  |
| Yes | No | | Have you ever been, or are you currently involved in a business venture with any current or former patient or with a key third party of a patient? |
|  |  | |  |
| Yes | No | | Have you reported any malpractice claims or incidents to any carrier in the past ten years? If yes, please complete the Claims History Supplement. |
|  |  | |  |
| Yes | No | | Are you aware of any incidents, occurrences, accidents, conduct, or circumstances, complications, or unexpected outcomes resulting in injury or death that might reasonably be expected to result in a claim or suit known to you or which should have been known to you on the date of this application? **If yes**, please complete the Claims History Supplement. |

# H. DECLARATIONS

The undersigned declares that the statements set forth herein are true. The undersigned agrees that if the information supplied on this application changes between the date of this application and the effective date of the insurance, he/she (undersigned) will immediately notify the company of such changes, and the company may withdraw or modify any outstanding quotations, authorization or agreement to bind the insurance.

Signing of this application does not bind the applicant or the company to complete the insurance, but it is agreed that this application shall be the basis of the contract should a policy be issued, and it will be attached to and become a part of the policy.

All written statements and materials furnished to the company in conjunction with the application are hereby incorporated by reference into the application and made a part hereof.

**NOTICE TO APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Physician’s Personal Signature |  | Date |

Agent/Producer Name: License #:

Signature of Agent/Producer:

Address:

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTES SECTION**

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| **Question #** |  | **Comments** |
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