DOCTORS professional liability

Supplemental Application for Pain Management

Full Name of Applicant: _____

1. Certifications:
   a. Anesthesia ☐ Yes ☐ No
   b. Pain Management ☐ Yes ☐ No
   c. Other: _____
2. Fellowship in Pain Management: _____ Date: _____
   If no Fellowship, please list any other applicable training, including all CME credits inPain Management in the past 3 years. _____
   _____
   _____
3. What percentage of your Pain Management practice is?
   Terminal: _____ Non-terminal: _____ Both: _____
4. Are you ACLS Certified? ☐ Yes ☐ No
   If not, is someone in the immediate area of your procedures ACLS certified? ☐ Yes ☐ No
5. List all facilities in which you do Pain Management procedures:
   _____
   _____
   _____
6. Do you require patients to whom you prescribe controlled substances for chronic pain to sign an agreement or contract stipulating indications and risk for these medications and consequences of violating the Agreement? ☐ Yes ☐ No
7. If you do any investigative or experimental procedures, please provide the name and address of the responsible granting or oversight committee:
   _____
   _____
   _____
8. Are you in a group? ☐ Yes ☐ No
   Group Name: _____
9. Do you practice with other pain management physicians? ☐ Yes ☐ No

   With what other specialist do you practice? _____

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10. Does your group have a credentialing process for the practice of pain management? ☐ Yes ☐ No

11. What percentage of your practice is pain management? _____%

12. Do you require your pain management patients to have an attending or primary care physician? ☐ Yes ☐ No

13. Does your pain management practice have a Ph.D. Clinical Psychologist associated with it? ☐ Yes ☐ No
    What percentages of patients are referred to him/her? _____%
    If you answered Yes to the above question, please confirm that the provider has policy limits equal to or excess of your limits of liability and please provide a copy of the declarations page of their policy. ☐ Yes ☐ No

14. What procedures and or modalities do you use in your practice? (Check All That Apply)

Level I	**Level II**	**Level III**
☐ Corticosteroid Injections	☐ Neuroablative Techniques	☐ Spinal Epiduroscopy/Myeloscopy
☐ Neural Blockades	☐ Neurostimulation Therapy	☐ Implanted Device-Please List
☐ Trigger Point Injections	☐ Opioid Therapy	
☐ Adjuvant Analgesics		

Other: _____

_____

15. Please specify any procedure not listed above for which you wish to be insured:

_____

_____

_____

_____

16. Do you perform Intravenous Ketamine Infusions? ☐ Yes ☐ No

17. Does the applicant perform Surgical and Minor Surgical and/or Invasive Procedures? ☐ Yes ☐ No

    If yes, complete the following:

    a. Total number of Minor Surgical / Invasive Procedures

        Past 12 months: Next 12 Months

b. Who performs surgical and/or minor surgical / Invasive Procedures?

_____

_____

_____

_____

c. Do any of the procedures performed under General Anesthesia?

_____

_____

_____

_____

d. Provide a complete list of all surgical and minor surgical / invasive procedures being performed (attached a separate sheet if necessary):

_____

_____

_____

_____

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

The policy applied for is SOLELY AS STATED IN THE POLICY, if issued, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE “CLAIMS” THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD, unless the Optional Extension Period option is exercised in accordance with the terms of the policy.

The underwriting manager, Company and/or affiliates thereof is authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which the underwriting manager, Company and/or affiliates thereof receives notice is on file with the underwriting manager, Company and/or affiliates thereof and is considered physically attached to and part of the of the policy if issued. The underwriting manager, Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the underwriting manager, Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

WARRANTY

I warrant to the Company, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.

Must be signed by the Applicant within 60 days of the proposed effective date.

_____	_____
Name of Applicant	Title
_____	_____
Signature of Applicant	Date

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