DOCTORS professional liability

Request for Part-Time Coverage

1. Name: _____ ___ MD ___ DO Other: _____
2. Policy No: _____ *(leave blank if you do not have your professional liability insurance with DPL)*
3. Effective Date for Part-Time Coverage _____
4. Number of hrs. per week for which coverage is requested _____

   Patient load per week _____

   (Practice hrs. consist of: hospital rounds, call hours involving patient contact, communication with other physicians, patient visits and charting.)
5. If 20 hrs. or less, how long have you practiced part-time? _____
6. Coverage specialty requested _____
7. Part-time description:
   - ☐ Pregnancy or dependent care
   - ☐ Semi-retirement: Date of Birth
   - ☐ Disability Type: _____ *(Submit written explanation from treating physician)*
   - ☐ Majority of time spent in a teaching capacity. Hours/week _____ Place _____
   - ☐ Majority of employment insured through hospital
   - ☐ Majority of employment in another state, which is insured elsewhere: State _____
   - ☐ Majority of practice is insured through another carrier, entity or employer
8. How long do you anticipate your coverage will be at these reduced hours? _____
9. **Submit proof of coverage for any employment listed above which is to be excluded on your DPL policy.**

_____ _____

Signature Date

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