Medical Director's Professional Liability Application

All information below must be completed and all questions answered "Yes" or "No". Please provide any extra explanations on a separate page. Submit this form with a copy of state license, CV and signed No Known Loss.

Physicians Information:

1. Full Name of Applicant: _____
2. Mailing Address: _____

   _____
3. Medical License # & State of Issuance: _____
4. Date of Birth: _____ Place of Birth: _____
5. Medical School & Year of Graduation: _____
6. Medical Specialty: _____ Sub-Specialty: _____
7. Are you American Board Certified? ○ Yes ○ No

   If Yes, what specialty? _____ Year Certified: _____

Entity Information:

1. Name & Location of facility where Medical Director services are performed:

   _____

   _____

   _____
2. Your relation to this entity: _____

   ○ Owner / Partner ○ Contractor ○ Employee

   ○ Other. Provide Details: _____
3. When was the facility established?

   _____

   _____

   _____
4. Type of Facility – describe in detail medical services provided:

   _____

   _____

   _____

5. Does this entity have any beds for overnight occupancy? ○ Yes ○ No

   If Yes, how many beds is this facility licensed for? _____

6. What is the total number of outpatient visits and / or tests per year at this facility? _____

   _____

7. Is surgery performed at this facility? ○ Yes ○ No

   If Yes, How many surgeries per year? _____

8. Are obstetrics practiced at this facility? ○ Yes ○ No

   If Yes, How many surgeries per year? _____

9. Business operated as Medi-spa? ○ Yes ○ No

10. Do all Professionals have licenses? ○ Yes ○ No

11. Annual gross receipts from all operations? _____

12. Do you need coverage for Guest Medical Directors? ○ Yes ○ No

    Name of Doctor: _____ Type of Doctor: _____

13. List all services for which you are a medical director:

    _____

    _____

    _____

    _____

14. Do all locations use consent forms for each patient? (*If yes, please attach*) ○ Yes ○ No

15. Do you do any direct patient care? ○ Yes ○ No

    If yes, please describe: _____

    _____

    _____

16. Are you aware of any incidents that could arise as claims to any facility? ○ Yes ○ No

    If yes, please describe: _____

    _____

    _____

17. State the approximate division of patients at the facility:

_____% Alcoholics / Drug Addicts	_____% Counseling / Family Planning
_____% Dental / Orthodontic	_____% General Public
_____% Hemodialysis	_____% Holistic Medicine / Acupuncture
_____% Mentally Retarded	_____% Obstetrical

_____% Pediatric _____% Psychiatric

_____% Research or Experimental _____% Physicians – Minor Surgery

_____% Surgical _____% Other: _____

18. List the number & type of employees at this facility:

_____Inhalation Therapists _____Nurse Registered

_____Laboratory Technicians _____Opticians

_____Nurse Anesthetists _____Optometrists

_____Nurses, Licensed Practical _____Pharmacists

_____Perfusionists _____Physicians – minor surgery

_____Social Workers _____Speech Therapists

_____Physicians – no surgery _____Other: _____

_____Nurse Practitioner

19. List the number and type of contractors who provide professional services at this facility.

_____

_____

20. Are all physicians, whether employed or contracted, required to carry medical malpractice insurance? ○ Yes ○ No

If Yes, What limits of liability? _____

21. All locations must have professional liability / malpractice insurance for all services provided. Please Attach a Copy of the Declarations page.

22. Is this facility currently insured under a Commercial Liability Policy? ○ Yes ○ No

If Yes, what is the name of the CGL carrier? _____

Medical Director Service Information:

1. How many hours per week are dedicated to medical director services only? _____

2. Do you also provide medical services at this facility other than the medical director? ○ Yes ○ No

If Yes, how many hours and what services? _____

_____

3. How long have you worked as medical director at each facility?

_____

_____

4. Please describe your duties as medical director: _____

_____

_____

I understand:

1. No medical director coverage will be offered for any service unless specifically approved by underwriters.
2. If I am aware of any claim or incident that could arise from any of the locations where I will be working, that occurred while I was the medical director there, I have indicated it on this application.

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