Podiatry Application

I. PERSONAL INFORMATION

Full Name of Applicant: _____ _____ _____ _____
FIRST MIDDLE LAST SUFFIX

Professional Designation: ☐ **D.P.M** Date of Birth: _____ _____ _____ Gender: ☐ Male ☐ Female
MONTH DAY YEAR

Place of Birth: _____ Social Security Number: _____

II. OFFICE INFORMATION

Principal Office Address: _____

_____ _____ _____ _____
City County State Zip

Office Phone Number: _____ Office Fax Number: _____

Email Address: _____ Office Manager: _____

Secondary Office Locations (If any): _____

_____ _____ _____ _____
City County State Zip

III. COVERAGE REQUEST

Requested Effective Date: _____ _____ _____ Retroactive Date: _____ _____ _____
MONTH DAY YEAR MONTH DAY YEAR

Please indicate your desired level of coverage in the appropriate box.

☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $250,000/$750,000

☐ $500,000/$1,500,000 ☐ $1,000,000/$3,000,000

IV. CLASSIFICATION, LICENSING AND BOARD CERTIFICATION 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. Indicate the average number of: Patients seen per week: _____ Hours practiced per week: _____
E. Licensing (List all states in which you are currently licensed.) _____

State	Medical License Number	% of Practice	Federal DEA License Number & Status	Member of State Medical Association
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

F. If you are a foreign graduate, are you certified by the Educational Commission for Foreign Medical Graduates? ○ Yes ○ No ○ N/A

G. Are you American Board Certified? ○ Yes ○ No

a. If "yes," list Specialty Board(s): _____ (Indicate allopathic or osteopathic)

b. If "yes," list date of initial Board Certification: _____

H. Please indicate the number of Continuing Medical Education (CME) credit hours you have attained over the past 12 months: _____

V. PODIATRY PROCEDURAL QUESTIONS

Please review each of the following classifications of coverage. After reviewing, please INDICATE the appropriate class (Class I, Class II or Class III) that describes your practice.

☐ **Class I - No Surgery**

By checking the No Surgery box above you are attesting that you do NOT render any Professional Service listed below, even if such Professional Services are otherwise within the scope of your license to practice podiatry:

1. any procedures performed at or above the level of the ankle joint;
2. the administration of anesthesia other than topical or by means of local infiltration;
3. assisting in the performance of any Podiatric surgical procedure;
4. the reduction of any fracture;
5. the use of lasers;
6. the performance of any procedure involving the cutting or penetration of any tissue, except:
    a. incision, and/or drainage of sebaceous cysts, abscesses or hematoma;
    b. curettage of verrucae;
    c. incision and removal of foreign body from the superficial or subcutaneous tissue;
    d. debridement of infected skin, abrasions or keratotic lesions;
    e. debridement, excision or avulsion of nail plate, excluding permanent removal except those procedures which involve the use of electrical or chemical cautery;
    f. needle penetration of the skin and blood vessels;
    g. treatment of burns except the local treatment of third degree burns;

h. closed manipulative reduction of fractures of metatarsals and phalanges.

☐ **Class II – Intermediate Surgery**

By checking the Intermediate Surgery box above you are attesting that you do NOT render any Professional Service listed below, even if such Professional Services are otherwise within the scope of your license to practice podiatry:

1. the treatment or reduction of compound fractures of the calcaneus or talus;
2. triple arthrodesis;
3. surgical procedures at or above the level of the ankle joint, which includes, but is not limited to, those parts of the tibia, fibula, their malleoli and their related structures;
4. surgical procedures at or above the level of the ankle joint involving arthroplasty, osteotomy, grafts, implants and arthrodesis;
5. surgical treatment of the muscles and tendons at or above the level of the ankle joint;
6. the administration of general anesthesia.

☐ **Class III – Major Surgery**

By checking the Major Surgery box above you are attesting that you do NOT render any Professional Service listed below, even if such Professional Services are otherwise within the scope of your license to practice podiatry:

1. the administration of general anesthesia;
2. surgical procedures above the level of the ankle joint.

1. Do you have a certificate to perform ankle surgery? ○ Yes ○ No
2. Do you use implants? ○ Yes ○ No
   If YES, what type and for what purpose? _____
   _____
3. Do you perform any plastic or cosmetic surgery? ○ Yes ○ No
   If YES, list all procedures: _____
   _____
4. Do you perform procedures intended to lengthen or shorten the leg? ○ Yes ○ No
5. Do you perform any lower leg deformity correction procedure ○ Yes ○ No
   If YES, list all procedures: _____
   _____
6. Do you treat any podiatric conditions which fall outside the areas covered in your state's Podiatric Practice Act or do you assist in surgeries outside your state's Podiatric Practice Act (i.e. knee, hip, legs, etc.)? ○ Yes ○ No
   If YES, please explain: _____
   _____

7. Do you use Lasers? ○ Yes ○ No

   If YES, please answer the following:

   a. For what types of treatment do you use a Laser?

   b. How many times per week do you perform Laser surgery?

   c. Please indicate the type of training you received in Laser surgery. Please check all that apply.

      ☐ 1) Seminar ☐ 2) Hands on ☐ 3) Other _____

      ☐ 4) Course ☐ 5) Preceptorship

   d. Please specify the name(s) of training program(s): _____

8. Do you administer any of the following types of anesthesia or do you perform any of the following procedures? If answer is "YES", check all appropriate locations where performed:

a) Acupuncture	☐ Yes ☐ No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
If YES, for anesthesia?	☐ Yes ☐ No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
b) Caudal	☐ Yes ☐ No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
c) Digital Block	☐ Yes ☐ No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
d) General Anesthesia	☐ Yes ☐ No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
e) Intravenous Anesthesia	☐ Yes ☐ No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
f) Intravenous Analgesia	☐ Yes ☐ No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
g) Local	☐ Yes ☐ No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
h) Nitrous Oxide	☐ Yes ☐ No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
i) Pain Blocks	☐ Yes ☐ No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
j) Pain Management	☐ Yes ☐ No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
If YES, complete a Pain Management Questionnaire				
k) Peripheral Nerve Block	☐ Yes ☐ No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
l) Spinal Anesthesia	☐ Yes ☐ No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility
m) Other Anesthesia	☐ Yes ☐ No	☐ Hospital	☐ Surgicenter	☐ Non-hospital facility

If YES, specify types:	

9. Have you assumed supervisory duties over any nurse anesthetists? ○ Yes ○ No

VI. ADDITIONAL PROFESSIONAL INFORMATION - If you answer "yes" to any of these questions please provide details.

A. Has your license to practice or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? ○ Yes ○ No

B. Have your hospital staff privileges ever been suspended, revoked, voluntarily surrendered, or in any way restricted? ○ Yes ○ No

C. Have you ever been refused hospital privileges? ○ Yes ○ No

D. Have you ever failed any licensing or Board Certification examinations? ◉ Yes ◉ No
If yes, how many times? _____

E. 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

F. 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 committees? ○ Yes ○ No

G. 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

H. 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

I. Have you ever been accused of sexual misconduct of any kind? ○ Yes ○ No

J. 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

K. Have there been any changes in your specialty or practice activities (including the addition of new procedures) within the past ten years? ○ Yes ○ No
If YES, please provide details: _____

L. Do you anticipate any changes in your specialty or practice activities (including the addition of new procedures) in the next year? ○ Yes ○ No
If YES, please provide details: _____

M. Do you perform any procedures not routinely performed by other persons practicing your specialty or subspecialty? ○ Yes ○ No

N. Do you provide medical services within the confines of any state, local or federal correctional facility, jail or prison? ○ Yes ○ No

O. 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? _____
Are you contracted with a facility or are these your own private practice patients? _____

P. Do you serve as a medical director of a hospital, nursing home, or other facility? ○ Yes ○ No
If YES, please provide details: _____

Q. 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 (i.e. teleradiology, telemedicine or internet medicine)? ○ Yes ○ No
If YES, please provide details: _____

VII. EDUCATIONAL INFORMATION

MEDICAL SCHOOLS

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

RESIDENCIES, FELLOWSHIPS, AND OTHER POST-GRADUATE TRAINING

INSTITUTION	LOCATION	SPECIALTY OR DEPARTMENT	DATES (MONTH/YEAR)		WAS THE TRAINING FULLY COMPLETED?
			START	END	
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

VIII. PRACTICE LOCATIONS HISTORY

PLEASE LIST ALL LOCATIONS WHERE YOU HAVE PRACTICED SINCE RESIDENCY

LOCATIONS	DATES (MONTH/YEAR)	
	START	END

IX. PRACTICE ORGANIZATION

☐ If a Solo Practice: Name of your Corporate entity and/or DBA name: _____

☐ If a Member of a partnership or multi-shareholder corporation / Partnership/Group Name: _____

_____

☐ Work as an Employee or Independent Contractor for Other - please explain and provide name of Entity/Practice you are working for: _____

X. INFORMATION ON ALLIED HEALTH CARE PROFESSIONALS

A. List below any Ancillary or Allied Health Care Professionals associated with your practice: 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?
		☐ Employee	☐ Contractor	☐ Yes ☐ No
		☐ Employee	☐ Contractor	☐ Yes ☐ No
		☐ Employee	☐ Contractor	☐ Yes ☐ No
		☐ Employee	☐ Contractor	☐ Yes ☐ No

B. Do any of your employees practice at a location geographically separate from yours? ○ Yes ○ No
If "yes", please explain. _____

XI. 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
NAME	MAILING ADDRESS	START	END		
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

XII. PROFESSIONAL LIABILITY INSURANCE & CLAIMS HISTORY

INSURANCE COMPANY NAME	# OF CLOSED CLAIMS	# OF PENDING CLAIMS	POLICY DATES		RETROACTIVE DATE	TALL COVERAGE PURCHASED?
			FROM	TO		

A. Has any insurance company ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? ○ Yes ○ No

B. In the past 10 years, have you ever been involved in a malpractice claim or suit, either directly or indirectly? (THIS INCLUDES ANY WHICH HAVE BEEN CLOSED or DISMISSED) If "yes," how many? _____ ● Yes ● No

C. Other than the claims/suits indicated in 12B, 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? If you respond YES to any of the below questions, then you must provide additional information.

   a. A request for records from a patient and/or attorney related to an adverse outcome? ○ Yes ○ No

   b. A letter from an attorney regarding your medical treatment of a patient? ○ Yes ○ No

   c. Intra-operative or post-operative complications or any other type complications resulting in death, paralysis, other significant disability or the need for follow-up surgery? ○ Yes ○ No

   d. Patient or family member dissatisfaction with the outcome of a procedure treatment or diagnosis? ○ Yes ○ No

   e. Any other incidents or circumstances that might reasonably lead to a claim or suit? ● Yes ● No

D. HAVE ALL INCIDENTS & 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 PREVIOUS PROFESSIONAL LIABILITY INSURANCE CARRIER? ● N/A ● Yes ● No

IMPORTANT!!!!! Please note that a NO answer to question D indicates that you are aware of a potential CLAIM OR SUIT but have not yet reported it to your current insurance company. Using a separate page, please provide the name of the patient you are referring to along with a detailed narrative as to what transpired and the date that the incident in question took place.

I HEREBY REPRESENT THAT THE AFOREMENTIONED STATEMENTS AND ANSWERS ARE CORRECT AND COMPLETE. I FURTHER UNDERSTAND THAT MY ANSWERS AND STATEMENTS WILL BE THE BASIS FOR DETERMINING MY INSURABILITY AND PREMIUM FOR THE PROFESSIONAL LIABILITY INSURANCE BEING APPLIED FOR. I FURTHER UNDERSTAND THAT THE COMPLETION AND SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THIS INSURANCE. ANY PERSON WHO KNOWINGLY OR WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY MATERIAL FACT THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

ACKNOWLEDGED AND AGREED:

Applicant Name (Printed)	Applicant Signature (Required)	Date Signed

PLEASE PROVIDE THE FOLLOWING WITH THE APPLICATION or AS SOON AS POSSIBLE AS THEY ARE ITEMS REQUIRED BY UNDERWRITERS IF WE ARE TO PROVIDE YOU WITH PROMPT SERVICE AND FASTER TURN AROUND TIME ON QUOTING – THANKS!

☐ **APPLICATION MUST BE SIGNED AND DATED AT TIME FIRST COMPLETED AND SENT BACK TO US.**

☐ **Please provide your expiring insurer policy Declarations Page showing Retroactive Date – a must if requesting Prior Acts Coverage.**

☐ **Please provide copies of any applicable current policy endorsements that affect basis of coverage so that we are able to try and obtain coverage aspects equal to or better than what you currently have in place.**

☐ **Please provide a copy of an Up-to-date CV (curriculum vitae - also known as a resume).**

☐ **Please provide current (*i.e. obtained within 60 days of requested effective date*) Claims History / Loss Run reports from all Prior Insurance Companies over the last 10 years – WE WILL BE GLAD TO TRY AND HELP YOU OBTAIN THESE IF NECESSARY.**

If you have the need to provide additional info or to elaborate on previous YES responses please do so in the space provided below:

DOCTORS professional liability

Supplemental Claims Information

If reporting 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. Relationship to Patient (Attending Physician, Surgeon, Consultant, etc.): _____
6. Allegations made about care rendered: _____
   _____
   _____
7. What is the present condition of the patient? _____
   _____
8. 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
9. 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

Unresolved/Open Claim:
☐ Waiting mediation
☐ Awaiting court action

☐ 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
Amt. of loss payment:
_____

Reserve Amount:
_____

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 _____
11. Explain, in detail, what action(s) you have taken to prevent recurrence of this type of claim: _____
    _____
    _____
    _____

Signature: _____ Date: _____

Name(Printed): _____

23276 S. Pointe Dr. Suite 204 Laguna Hills , California 92653 * P 888-959-9456 * F 888-600-6280 * W www.DPLRRG.com