DOCTORS professional liability

Physician Assistant - Professional Liability Application

I. PERSONAL DATA

Name: _____ _____ _____
LAST FIRST MIDDLE INITIAL

Date of Birth: _____ License #: _____ DEA License #: _____

Email Address: _____ Social Security #: _____

Business Phone: _____ Business Fax: _____ Residence/Cell Phone: _____

Primary Practice Address: _____ City: _____

Country: _____ State: _____ Zip Code: _____

Percentage of your work that is performed at this location: _____

List any other states in which you are actively licensed, practicing in and requesting coverage for:

_____

Many state Medical Boards require a written Collaborative Agreement between a PA and a supervising physician. In California this is known as a "Delegation of Services" Agreement. Do you have a written agreement, such as this, in place with each physician designated as your supervisor? ○ Yes ○ No

Do you adhere to all requirements of the HIPAA Privacy Act? ○ Yes ○ No

Have you taken a patient safety or risk management course in the last three years? ○ Yes ○ No

If Yes, please submit a copy of the certificate as proof of completion.

Are you a member of a Professional Association? ○ Yes ○ No

If Yes, please list the name(s) of the Association(s): _____

II. PA CLASSIFICATION

Check off (✓) all area(s) that apply:

PA 1
- ☐ Practice is limited to performing tasks related to diagnostic treatment only (excludes Obstetrical)
- ☐ Operating Room exposure - exclusively for Observation only (excludes Obstetrical)
- ☐ Operating Room exposure - acting as 1st or 2nd assistant in surgery (excludes Obstetrical)
- ☐ Operating Room exposure - performing surgery under local anesthesia (excludes Obstetrical)
- ☐ Operating Room exposure - performing surgery under other forms of anesthesia (excludes Obstetrical)
- ☐ Any exposure to Trauma/Emergency Room procedures or responsibilities therein (excludes Obstetrical)
- ☐ Assisting in Anesthesiology administration (excludes Obstetrical)

PA 2
- ☐ Obstetrical exposure including 1st, 2nd or 3rd trimester prenatal care or postnatal care
- ☐ Obstetrical exposure including assisting in Obstetrical anesthesiology administration, delivery room responsibilities or assisting in C-section surgeries

III. SCOPE OF PRACTICE / WORK SETTING / EMPLOYMENT STATUS

Scope of Practice - Check off (✓) all area(s) that apply:

- ☐ Diagnostic Treatment
- ☐ Perform Minor Surgery
- ☐ Initiate Treatment Plans
- ☐ Health Counseling
- ☐ Routine Lab Testing
- ☐ Specialist Referral
- ☐ Long Term/Chronic Care
- ☐ OTHER
- ☐ Rehabilitation Treatment
- ☐ Prescribe/Dispense General Medications
- ☐ Prescribe/Dispense Controlled Substances
- ☐ Dermatology/Cosmetic Procedures
- ☐ Alternative/Complimentary Medicine Treatment
- ☐ Interventional Radiology Services
- ☐ Compile Patient Histories
- ☐ Pre/Post Op Procedures
- ☐ Behavioral Health
- ☐ Critical Care
- ☐ Patient Screening
- ☐ Pediatric Care
- ☐ Family Planning Services
- ☐ Perform Physical Exams

Work Setting - Check off (✓) all area(s) that apply:

- ☐ Hospital In-Patient Unit
- ☐ School/Health Dept
- ☐ Nursing Home/LTC
- ☐ Walk-in Urgent Clinic
- ☐ Home Health Care or Hospice
- ☐ OTHER
- ☐ Behavioral Health Facility
- ☐ Outpatient Facility
- ☐ Surgical Center
- ☐ Primary Physician Office
- ☐ Correctional Facility
- ☐ Emergency/Trauma Unit
- ☐ Hospital Operating Room
- ☐ Specialty Physician Office
- ☐ MedSpa/Cosmetic
- ☐ Staffing Agency

Employment status - in the event you have more than one employer please check (✓) all that apply:

☐ Employee, defined as receiving a W-2 Form from your employer. If employee, name of your primary employer:

_____

☐ Self-employed Independent Contractor, defined as paying self-employment taxes using a 1099 Form

☐ Moonlighting & Fill In work. Please provide details: _____

_____

IV. INSURANCE COVERAGE REQUESTED

Limits of Liability:

- ☐ $100,000/$300,000 Louisiana
- ☐ $250,000/$750,000 Florida or Indiana
- ☐ $1,300,000/$3,900,000 (New York Only)
- ☐ $200,000/$600,000 Nebraska or New Mexico
- ☐ $1,000,000/$3,000,000 All Others

Requested Effective Date: _____

Do you need prior acts coverage? **(If so, you must provide the Retroactive Date or "Retro Date" of your current policy. Please provide a copy of your current Declarations page or Certificate of Insurance.)**

☐ YES, I need Prior Acts Coverage. My current Retro Date is _____

☐ NO, I have read and understand the Important Notice below about Claims-Made Coverage and do not need

Prior Acts Coverage.

An Important Notice about Claims-Made Coverage: If you are currently insured under a claims-made policy, it is important that you continue your coverage without interruption when moving to a new policy. This is known as "continuous retroactive coverage". By providing your current policy Declarations page and the Retro Date, upon approval of your application, your new policy with our program will provide you with ongoing "continuous" coverage from that Retro Date. This means that any claim that might occur on or after your Retro Date will be covered under your new policy.

If you do not provide your current Retro Date on this application, and do not elect to purchase Extended Reporting Period coverage from your current insurer ("Tail Coverage"), your previous Claims-Made coverage will lapse. This would leave you completely uninsured or "bare" meaning that neither your current insurer or this new policy would respond to any claims that may arise for that original policy period.

V. ATTESTATION INFORMATION

If you answer "Yes" to any of the questions below, provide a detailed explanation on a separate sheet of paper, Supplemental Claim Information Form, or in the Comment section provided as appropriate.

Within the past 10 years:

1.	Have you been convicted of a misdemeanor (other than traffic related) or felony or is any such charge pending?	○ Yes ○ No
2.	Have you been admitted to or sought treatment from any mental health or chemical/substance abuse program? If yes, please provide an explanation on a separate sheet of paper.	○ Yes ○ No
3.	Has your license or certification been denied, restricted, suspended, revoked, surrendered, put on probation or issued on a restricted basis? If yes, please provide an explanation on a separate sheet of paper.	○ Yes ○ No
4.	Have your privileges been denied, restricted, suspended, revoked or put on probation by any health care facility? If yes, please provide an explanation on a separate sheet of paper.	○ Yes ○ No
5.	Have you ever resigned from a healthcare facility while under investigation or to avoid possible disciplinary action?	○ Yes ○ No
6.	Has any hospital, as a result of reviewing your patient care or your performance, conducted a hearing or taken any action concerning your medical staff membership/privileges or required additional supervision?	○ Yes ○ No
7.	Have any complaints been registered against you with your state licensing body, regulatory body, professional association, employer or healthcare facility at which you practice(d)?	○ Yes ○ No
8.	Have you ever had a complaint, claim or suit brought against you for alleged sexual misconduct?	○ Yes ○ No
9.	Have you provided any care that resulted in a formal incident report or investigation by any healthcare facility?	○ Yes ○ No
10.	Have Medicare or Medicaid authorities ever investigated or brought charges against you?	○ Yes ○ No
11.	Have you provided any professional services without professional liability insurance?	○ Yes ○ No
12.	Have any insurers canceled coverage, declined coverage, refused renewal or renewed only under restrictive circumstances your professional liability coverage?	◉ Yes ◉ No

13.	Have you ever treated any patients by means of unconventional therapeutics, or have you utilized non-FDA approved experimental drugs other than through Institutional Review Board (IRB) approved research programs?	◯ Yes ◯ No
14.	Are you now or have you ever been, involved in a claim, suit, received a written request for treatment records arising out of the rendering or failure to render professional medical services? If “Yes”, how many? _____	◯ Yes ◯ No
15.	Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit being filed against you? This includes but is not limited to the following: Amputation - Death - Loss of Major Organ Function - Loss of Vision - Permanent Neurological Injury - Permanent Damage to a Patient related to an Injury during the Delivery of a Child	◯ Yes ◯ No
16.	Have you ever been contacted by a plaintiff's attorney or required to produce medical records or statements regarding any case that you have been involved with?	◯ Yes ◯ No

AUTHORIZATION

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.

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.

ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED.

_____	_____	_____
Signature	Print Name	Date

ADDITIONAL COMMENTS

_____

_____

_____

_____

_____

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