



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: _____

How many hours do you work: _____

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:

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

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

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

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

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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Have you ever resigned from a healthcare facility while under investigation or to avoid possible disciplinary action?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Have you ever had a complaint, claim or suit brought against you for alleged sexual misconduct?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Have you provided any care that resulted in a formal incident report or investigation by any healthcare facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Have Medicare or Medicaid authorities ever investigated or brought charges against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Have you provided any professional services without professional liability insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Have any insurers canceled coverage, declined coverage, refused renewal or renewed only under restrictive circumstances your professional liability coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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? _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No

