DOCTORS professional liability

CERTIFIED REGISTERED NURSE ANESTHETIST
PROFESSIONAL LIABILITY APPLICATION CLAIMS-MADE COVERAGE

I. INFORMATION

1) Full Name:_____ 2) Date of Birth:_____

3) DBA/Corp Name:_____

4) Mailing Address: _____

5) City: _____ 6) State: _____ 7) Zip code: _____

8) Phone:_____ 9) E-mail:_____

II. EDUCATION AND LICENSURE

1) Nursing School:_____ Month/Year of Completion

2) CRNA School:_____ Month/Year of Completion

3) License Number/State Certification: _____

4) If you are licensed in more than one state, please indicate which states: _____

5) Indicate the number of CME hours you have completed in the last two years:_____

6) Are you ACLS Certified? ☐ YES ☐ NO

III. PRACTICE INFORMATION

1. Coverage is required for which type of practice:
   a) Solo Practitioner, employee or independent contractor of _____
   b) ☐ Full-time ☐ Part-time ☐ MoonLighting
   c) If the practice for which coverage is requested is part time or moonlighting, please provide the name and address of your full time position, number of weekly hours and attach a Certificate of Insurance

_____

2. a) Principal practice location for which coverage is requested:_____
   b) Number of weekly hours for this practice location: _____
   c) This practice location is a(n) : ☐ Hospital ☐ Ambulatory Surgery Center ☐ Professional ☐ Office

3. a) Secondary practice location for which coverage is requested, if applicable._____
   b) Number of weekly hours for this practice location:_____
   c) This practice location is a(n): ☐ Hospital ☐ Ambulatory Surgery Center ☐ Professional ☐ Office

4. Provide the following:

	Weekly	Annually
a) Average number of patients that you saw during the past 12 months for all jobs	_____	_____
b) Estimated number of patients that you will see in the next 12 months for all jobs	_____	_____
c) Estimated number of patients that you will see during the next 12 months for all jobs for which coverage is requested	_____	_____

5. Please indicate the approximate percentage of your patients:

Bariatric	_____ %	Plastic/Cosmetic	_____%
Dental/Oral Surgery	_____ %	Podiatric	_____%
Obstetric	_____ %	General Surgery	_____%
Pediatric	_____ %	Pain Management	_____%
Ophthalmic	_____ %	Endoscopic	_____%
Orthopedic	_____ %	Other	_____%

6. What percentage of your practice constitutes general anesthesiologist/ anesthesia procedures? _____%

7. Are you supervised by an anesthesiologist available on premises at all times? ☐ YES ☐ NO

If no, what percentage of your practice is supervised by the following:

_____% Another CRNA	_____% Anesthesiologist	_____% Bariatric Surgeon
_____% Dental/Oral Surgeon	_____% Ophthalmologist	_____% Podiatrist
_____% Plastic/Cosmetic Surgeon		_____% Other Physician

8. Are you present in the operating room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care? ☐ YES ☐ NO

9. During administration of all anesthetic, do you use a pulse oximeter monitor? ☐ YES ☐ NO

10. During all anesthetics:
   a) Is an electrocardiogram continuously displayed? ☐ YES ☐ NO
   b) How often is arterial blood pressure determined and evaluated? _____
   c) How often is the heart rate determined and evaluated? _____
   d) How is circulatory function evaluated? _____

11. During all general anesthetics, do you use an end tidal CO2 monitor? ☐ YES ☐ NO

12. During all general anesthesia using an anesthesia machine do you:
   a. Use an oxygen analyzer with a low concentration limit alarm? ☐ YES ☐ NO
   b. Test proper functioning of alarms prior to each use? ☐ YES ☐ NO

13. When ventilation is controlled by a mechanical ventilator, do you:
   a. Use a device equipped with a full set of safety alarms? ☐ YES ☐ NO
   b. Test proper functioning of alarms prior to each use? ☐ YES ☐ NO

* EXPLAIN ANY **NO** ANSWERS TO QUESTIONS 8-13 BELOW:

IV. PRACTICE HISTORY

1) PRACTICE LOCATIONS – please attach a CV listing prior practice locations.

2) List your prior professional liability insurance for the last (5) years:

POLICY PERIOD	CARRIER	POLICY LIMIT	DEDUCTIBLE	TYPE OF POLICY	RETROACTIVE DATE	FULL TIME PRACTICE OR MOONLIGHTING

VI. COVERAGE REQUEST

Per Claim: _____ Retroactive Date* _____

Effective Date: _____ Limits of Liability _____

Annual Aggregate _____

*Please provide evidence of coverage back to retroactive date requested.

Print or type Name and Title **Signature** **Date**