Application for Limited Professional Liability Coverage Insured Paramedical Employee



	• Birmin • PO Box 590009 • Birmin	ngham, AL 35259-0009) • 800.282.6242 • Fax 205.86	·8.4040		
Rec	quested Effective Date: / /					
Nar	me (Last, First, MI):					
SSN: DOB:		Sex: Male	_ Sex: Male Female			
Hot	Home Address: State:				ZIP:	
Cur	rrent Employer:		Telephone Number:			
Bus	siness Address:	City:	State	e: ZIP	:	
1.	Profession:					
	Surgical Assistant Certif	fied Nurse Practitioner fied Registered Nurse A rechnologist				
2.	Is your employer insured by a ProAssurance Company?				Yes No No	
3.	Have you ever:					
	A. Been convicted of a criminal offense?	.111	4		Yes No No	
	B. Been treated for (or recommended for treatment for) alcoholism, sexual, or drug addiction?C. Undergone psychiatric treatment?				Yes ☐ No ☐ Yes ☐ No ☐	
	D. Had a complaint filed against you with any hospital or regulatory board?				Yes No No	
	Had any professional license/permit or narcotics licer or placed under probation?		nded, revoked, restricted,		Yes	
	If the answer to 3.A., 3.B., 3.C., 3.D., or 3.E. is yes, pl	ease provide complet	te details on a separate she	et of paper.		
4.	Do you moonlight (work outside control of employer)? If	yes, where?			Yes No	
5.	Do you have your own separate practice without a collabo	orating physician?			Yes 🗌 No 🗍	
6.	Do you hold the certification of licensure required in your	state to practice your p	profession?		Yes 🗌 No 🔲	
	If yes, where did you receive your training?					
7.	Are you a member of any professional organization? If yes	s, please give details.				
8.	Have any judgments ever been rendered against you or any behalf from an incident alleging professional errors or omi		ents in excess of \$500 been m		Yes 🗌 No 🗍	
	If yes, please give details on a separate sheet. If available, p		complaint.			

If yes, please provide the reason(s) for the adverse underwriting decisions in the space provided at the end of the application. 11. Does your supervising physician regularly review medical records and cases with you? Yes 12. Is your clinical competency validated by the physician? Yes 13. Will you be scheduled to work at a separate location from your supervising physician? If yes, please give details on a separate sheet. 14. Does your practice comply in every way with the rules and regulations as set forth by the agency in your state charged with licensing and monitoring individuals in your profession? Yes 15. Do you elicit, record, and evaluate a health, psychosocial, and developmental history of the patient? Yes 16. Do you order or perform diagnostic tests? Yes 17. Do you discriminate between normal and abnormal findings on the history, physical, examination diagnostic tests, initiate referrals and consultations when needed? Yes 18. Do you regulate or adjust medications and treatment as prescribed by or authorized by a licensed physician? Yes 19. Do you perform a physical examination? If yes, briefly describe techniques and instruments used: 20. Do you conduct informed consent discussions? Yes 21. Describe any other procedures, treatments, or duties you perform: 22. Do you provide any cosmetic procedures/services? Yes If yes, please indicate which procedures. Botox Derma Fillers Laser Hair Removal Microdermabrasion Laser Hair Removal	9.	Has any action been filed against you or have you been against you alleging professional errors or omissions?	notified that any	action, regardless	of dollar amount, will be filed	Yes 🔲 No 🛭
cever canceled, declined to issue, refused for cnew, surcharged your promium, or issued coverage with any restrictions or exclusions? (This quation in an applicable in this surch in the space provided at the end of the application. 11. Does your supervising physician regularly review medical records and cases with you? Yes 12. Is your clinical competency validated by the physician? 13. Will you be scheduled to work at a separate location from your supervising physician? 14. Does your practice comply in every way with the rules and regulations as set forth by the agency in your state charged with Incensing and monitoring individuals in your profession? Yes 15. Do you clicit, record, and evaluate a health, psychosocial, and developmental history of the patient? Yes 16. Do you obscriminte between normal and abnormal findings on the history, physical, examination diagnostic tests? Yes 17. Do you discriminte between normal and abnormal findings on the history, physical, examination diagnostic tests, initiate referrals and consultations when needed? 18. Do you perform a physical examination? 16. If yes, briefly describe techniques and instruments used: 19. Do you perform a physical examination? 16. If yes, please indicate which procedures, reatments used: 20. Do you conduct informed consent discussions? Yes 21. Describe any other procedures, treatments, or duties you perform: 22. Do you perform Deliveries as a midwife? 16. If yes, please answer the following questions: A. How many deliveries are performed annually by midwife? B. Do midwives perform assisted Vaginal Deliveries? Yes No C. Do Midwives perform mone or birthing center deliveries? Yes No F. Do Midwives perform home or birthing center deliveries? Yes No G. As a mid-level provider do you follow alternative birthing plans? Yes No If yes, please describe:		If yes, please give details on a separate sheet. If availabl	le, please enclose	copy of complaint.		
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24. Describe your procedure for notifying your supervising physician of situations beyond the scope of your training or practice:	a :					
	24.	Describe your procedure for notifying your supervising	g physician of siti	ations beyond the	scope of your training or practice:	

	State	License Number	Renewal Date	
Ple	ase include copies of the following:			
Ple A.	ase include copies of the following: Current Curriculum Vitae			
		supervision form		
A.	Current Curriculum Vitae	_		
А. В.	Current Curriculum Vitae Copy of your approved notification of	_		

Fraud Warning - I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

Consent to Conditions of Consideration of the Application for Insurance

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

Authorization to Release Information

I, the undersigned hereby authorize my present and prior professional liability carriers, any and all attorneys who have represented me in connection with any claim of professional liability, and any other individuals, associations or entities having information regarding me, to release to ProAssurance upon its request, any information which in the judgment of any such person noted above, may have bearing upon my acceptability to ProAssurance as a professional liability risk, including but not limited to closed, pending or anticipated claims, underwriting or other information.

I hereby release and agree to hold harmless all persons or organizations, their agents, servants, and employees, ProAssurance, its directors, officers, employees and agents from any liability arising from releasing the above information, notwithstanding the fact that there may be errors, omissions or mistakes contained in such released information.

I further agree that ProAssurance and all persons and organizations described above may rely upon a photo copy of this Authorization, which shall be of equal validity with the signed original.

Risk Management Agreement Language

I agree that my office staff and I will comply with all Ob-Gyn Risk Alliance risk management programs administered by ProAssurance companies. Our compliance includes cooperating with ProAssurance and its employees and independent contractors in all risk management assessments and recommendations, participating in educational programming, and committing to work with the Ob-Gyn Risk Alliance to improve patient care and thus reduce losses.

I agree to ensure that my staff will work to further such risk management collaboration and comply with all education and risk management improvement recommendations.

I understand that compliance with this statement is necessary for membership in the Ob-Gyn Risk Alliance Purchasing Group, and failure to comply may jeopardize further participation in the program.

Name (Printed):	
Applicant's Signature:	Date:
Note: ProAssurance's Privacy Policy can be found on ProAssurance.com.	
Insured Physician's Authorization I hereby request the above applicant be added to my Policy as an Insured Paramedical Employee. I	understand that such coverage is subject
to underwriting approval.	S ,
Requested Effective Date:	Shared Limits Coverage
	Separate Limits Coverage
	Note: Separate Limits Coverage is not available for Cytotechnologists.
Signature of Insured Physician/Supervising Physician	Date

Please Print Name