

Medical Corporation Professional Liability Supplemental Application



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Completion of this supplemental application is required as a participant in the Ob-Gyn Risk Alliance program. Please be advised all information disclosed on this form is subject to the anti-fraud statement contained on your initial application.

Physician Name: _____

Are you currently a ProAssurance insured? Yes No Policy Number: _____

1. Hospital Information

Answer the following questions for each hospital listed on your initial application:

- A. Are fetal monitoring strips stored digitally? Yes No
If no, how are they stored?
Hospital 1: _____
Hospital 2: _____
Hospital 3: _____
Hospital 4: _____
- B. Do any of these hospitals use laborists? Yes No
If yes, which hospital(s)? 1 2 3 4
- C. Can the physician(s) remotely view the hospitals' electronic fetal monitoring (EFM) strips? Yes No
If yes, which hospital(s)? 1 2 3 4
- D. Does the hospital require physicians to have EFM interpretation certification to grant Ob privileges? Yes No
If yes, which hospital(s)? 1 2 3 4
- E. Does each of the hospital(s) where the physicians deliver require specialty specific certification for their perinatal nurses? Examples include: the Neonatal Resuscitation Program (NRP), the Association for Women's Health, Obstetric and Neonatal Nursing (AWOHNN certification), fetal monitoring, or the Advanced Practice Strategies fetal monitoring course. Yes No
If yes, which hospital(s)? 1 2 3 4
- F. Do physicians and nurses have regularly scheduled case study discussions or training opportunities? Yes No
If yes, which hospital(s)? 1 2 3 4
- G. Are debriefings performed when unanticipated clinical outcomes occur? Yes No
If yes, which hospital(s)? 1 2 3 4
- H. Have any of the hospital(s) where the physician(s) deliver adopted Institute of Healthcare Improvement's (IHI's) Elective Induction Safety Bundle? Yes No
If yes, which hospital(s)? 1 2 3 4
- I. Have any of the hospitals where the physicians deliver adopted IHI's Elective Augmentation Safety Bundle? Yes No
If yes, which hospital(s)? 1 2 3 4
- J. What is the maximum amount of time it takes to perform an emergency C-section once it is determined that one is necessary?
Hospital 1: _____ minutes
Hospital 2: _____ minutes
Hospital 3: _____ minutes
Hospital 4: _____ minutes

- K. Please answer the following question regarding access to a C-section/Anesthesia team:
- Hospital 1: Is there a C-section/Anesthesia team onsite? Yes No
 If no, indicate the team's response time when called: _____
- Hospital 2: Is there a C-section/Anesthesia team onsite? Yes No
 If no, indicate the team's response time when called: _____
- Hospital 3: Is there a C-section/Anesthesia team onsite? Yes No
 If no, indicate the team's response time when called: _____
- Hospital 4: Is there a C-section/Anesthesia team onsite? Yes No
 If no, indicate the team's response time when called: _____
- L. Do(es) the hospital(s) routinely schedule the following obstetrical emergency drills? Yes No
 If yes, which hospital (s)?
- | | | | | |
|------------------------------|---|---|---|---|
| Dystocia Drills | 1 | 2 | 3 | 4 |
| Maternal CPR | 1 | 2 | 3 | 4 |
| Clinical Simulation Training | 1 | 2 | 3 | 4 |
- M. Is EFM performed on active labor patients? Yes No
 If yes, which hospital(s)? 1 2 3 4
- N. Are placentas maintained for at least seven days post-delivery? Yes No
 If yes, which hospital(s)? 1 2 3 4
- O. Is structured communication (e.g. SBAR) used between physicians and nursing staff to relay patient information? Yes No
 If yes, which hospital(s)? 1 2 3 4

2. Mid-Level Provider Information – CNM, CRNP, CRNA

- A. Are all employed mid-level provider(s) currently certified and licensed through recognized accrediting/licensing agencies? Yes No
- B. Are employed mid-level provider(s) clinical competency validated by the physician(s)? Yes No
- C. Do(es) the physician(s) regularly review medical records and cases with employed mid-level provider(s)? Yes No
- D. Do(es) any employed mid-level provider(s) follow alternative birthing plan? Yes No
 If yes, please describe: _____
- E. Are nurse midwives employed? Yes No
 If yes, please answer the following questions:
- Do midwives perform deliveries? Yes No
 If yes, how many deliveries do they perform annually? _____
 - Do midwives perform inductions/augmentation? Yes No
 - Do midwives perform assisted vaginal deliveries? Yes No
 If yes, is the physician present? Yes No
 - Do midwives perform VBAC deliveries? Yes No
 If yes, is the physician present? Yes No
 - Do midwives perform underwater births? Yes No
 - Do the nurse midwives perform home or birthing center deliveries? Yes No
- F. Do(es) the mid-level provider(s) perform any procedures? Yes No
 If yes, please list the procedures, (e.g. Botox, derma fillers, laser hair removal) and also note where the procedures are performed (office/hospital/surgery center).
- Procedure: _____ Location: _____
- Procedure: _____ Location: _____
- Procedure: _____ Location: _____
- Procedure: _____ Location: _____

3. Office Practice Information

- A. Do(es) the physician(s) provide laborist services to the hospital(s)? Yes No
If yes, which hospital(s)? 1 2 3 4
- B. Is the practice able to interface with the hospital's electronic health record (EHR) system? Yes No
If yes, which hospital(s)? 1 2 3 4
- C. Are any of the following Ob-Gyn office procedures performed? Yes No
If yes, please check to indicate which office procedures are performed:
- | | | |
|--|--|---|
| <input type="checkbox"/> Colposcopy | <input type="checkbox"/> Biopsy | <input type="checkbox"/> LEEP |
| <input type="checkbox"/> Cryosurgery | <input type="checkbox"/> IUD | <input type="checkbox"/> Non-Invasive Permanent Birth Control |
| <input type="checkbox"/> Subdermal Contraceptive | <input type="checkbox"/> Bio-Identical Hormone Replacement Therapy | <input type="checkbox"/> Ablation |
| <input type="checkbox"/> Fertility Treatment | <input type="checkbox"/> Non-stress Testing | <input type="checkbox"/> Urodynamic Testing |
| <input type="checkbox"/> Pain Management | <input type="checkbox"/> Weight Loss Management/Treatment | <input type="checkbox"/> Amniocentesis |
| <input type="checkbox"/> Other (please list): _____
_____ | | |
- D. Do(es) the physician(s) or mid-level provider(s) address patient birthing plans? Yes No
- E. Do(es) the practice have an EHR? Yes No
If yes, what is the name of the EHR system? _____

Applicant's Signature: _____ Date: _____

Risk Management Agreement



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 educational 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.

Applicant's Signature: _____

Date: _____