

**ProAssurance American Mutual, A Risk Retention Group**

PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • Fax 205.868.4040

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                        |
- 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: \_\_\_\_\_