Medical Professional Liability Supplemental Application

Ob-Gyn Risk Alliance
Underwritten by ProAssurance Treated Fairly

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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. Physician Information

A. List the hospitals where you have privileges. Note: These hospitals will be referenced in this section and the "Hospital Information" section.

Hospital 1 Name: _____ Percentage of your patients admitted into this facility: _____%

Location: _____ Privileges: Active ☐ Pending ☐

Hospital 2 Name: _____ Percentage of your patients admitted into this facility: _____%

Location: _____ Privileges: Active ☐ Pending ☐

Hospital 3 Name: _____ Percentage of your patients admitted into this facility: _____%

Location: _____ Privileges: Active ☐ Pending ☐

B. Please provide the total number of deliveries that you have performed for the past year: _____

Spontaneous vaginal deliveries – number per year: _____

Vaginal assisted deliveries – number per year: _____

C-sections – number per year: _____

VBAC – number per year: _____

Unattached (No-doc) deliveries – number per year: _____

Unattended deliveries – number per year: _____

C. Does your hospital require you to remain in-house for VBAC patients?

Hospital 1: Yes ☐ No ☐ Hospital 2: Yes ☐ No ☐ Hospital 3: Yes ☐ No ☐

D. Do you allow patients to develop an alternative birthing plan? Yes ☐ No ☐

If yes, please list examples (e.g., water births, limited or no antenatal screening, or no continuous, invasive fetal monitoring): _____

_____

a. Do your partners or any on-call physicians follow established alternative birthing plans? Yes ☐ No ☐

If no, please explain: _____

E. Have you completed a fetal monitoring course or update within the previous 24 months? Yes ☐ No ☐

F. Have you incorporated the National Institute for Child Health and Development's (NICHD) standardized nomenclature for fetal monitoring interpretation into your practice? Yes ☐ No ☐

G. Do you perform labor epidurals? Yes ☐ No ☐

Do you have evidence of training and continuing education for labor epidurals? Yes ☐ No ☐

H. Do you supervise mid-level providers? Yes ☐ No ☐

Indicate number: CRNA _____ CNM _____ CRNP _____

I. Do you provide services or act as the medical director for any off-site delivery programs? Yes ☐ No ☐

If yes, please list: _____

2. Gynecology

A. Total number of annual gynecology surgery procedures: _____

B. Total number of annual hospital/outpatient facility procedures: _____

C. Have you been granted robotic assist surgery privileges? Yes ☐ No ☐

D. Do you perform any of the following office-based procedures or services? Yes ☐ No ☐

If yes, please check services performed:

- ☐ Colposcopy
- ☐ Biopsy
- ☐ LEEP
- ☐ Cryosurgery
- ☐ IUD
- ☐ Non-invasive permeant birth control
- ☐ Subdermal contraceptive therapy
- ☐ Bio-identical hormone replacement therapy
- ☐ Ablations
- ☐ Urodynamic testing/treatment
- ☐ Fertility treatment
- ☐ Pain Management
- ☐ Weight loss management
- ☐ Other

E. Do you provide any in office procedures requiring moderate sedation or anesthesia? Yes ☐ No ☐

F. Do you provide any in office or outpatient cosmetic procedures/services? Yes ☐ No ☐

If yes, please check services performed:

- ☐ Botox
- ☐ Derma fillers
- ☐ Laser hair removal
- ☐ Laser skin resurfacing
- ☐ Sclerotherapy
- ☐ Microdermabrasion
- ☐ Tumescent liposuction or liposuction
- ☐ Breast augmentation
- ☐ Breast reduction
- ☐ Breast reconstruction

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: _____