

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

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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

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