

Application for Limited Professional Liability Coverage Insured Paramedical Employee



ProAssurance Indemnity Company, Inc. • PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • Fax 205.868.4040

Requested Effective Date: _____ / _____ / _____

Name (Last, First, MI): _____

SSN: _____ DOB: _____ Sex: Male Female

Home Address: _____ City: _____ State: _____ ZIP: _____

Current Employer: _____ Telephone Number: _____

Business Address: _____ City: _____ State: _____ ZIP: _____

1. Profession:

- | | |
|--------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Certified Nurse Practitioner |
| <input type="checkbox"/> Surgical Assistant | <input type="checkbox"/> Certified Registered Nurse Anesthetist |
| <input type="checkbox"/> Certified Nurse Midwife | <input type="checkbox"/> Cytotechnologist |

2. Is your employer insured by a ProAssurance Company? Yes No

3. Have you ever:

- | | |
|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| A. Been convicted of a criminal offense? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| B. Been treated for (or recommended for treatment for) alcoholism, sexual, or drug addiction? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| C. Undergone psychiatric treatment? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| D. Had a complaint filed against you with any hospital or regulatory board? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| E. Had any professional license/permit or narcotics license investigated, suspended, revoked, restricted, or placed under probation? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

If the answer to 3.A., 3.B., 3.C., 3.D., or 3.E. is yes, please provide complete details on a separate sheet 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 collaborating physician? Yes No

6. Do you hold the certification of licensure required in your state to practice your profession? Yes No

If yes, where did you receive your training?

7. Are you a member of any professional organization? If yes, please give details.

8. Have any judgments ever been rendered against you or any out-of-court settlements in excess of \$500 been made on your behalf from an incident alleging professional errors or omissions? Yes No

If yes, please give details on a separate sheet. If available, please enclose copy of complaint.

9. Has any action been filed against you or have you been notified that any action, regardless of dollar amount, will be filed against you alleging professional errors or omissions? Yes No
 If yes, please give details on a separate sheet. If available, please enclose copy of complaint.
10. Has an insurance company that provided you medical professional liability or related coverage, including Lloyd's of London, ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? (*This question is not applicable in Missouri.*) Yes No
 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 No
12. Is your clinical competency validated by the physician? Yes No
13. Will you be scheduled to work at a separate location from your supervising physician? Yes No
 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 No
15. Do you elicit, record, and evaluate a health, psychosocial, and developmental history of the patient? Yes No
16. Do you order or perform diagnostic tests? Yes No
17. Do you discriminate between normal and abnormal findings on the history, physical, examination diagnostic tests, initiate referrals and consultations when needed? Yes No
18. Do you regulate or adjust medications and treatment as prescribed by or authorized by a licensed physician? Yes No
19. Do you perform a physical examination? Yes No
 If yes, briefly describe techniques and instruments used: _____

20. Do you conduct informed consent discussions? Yes No
21. Describe any other procedures, treatments, or duties you perform:

22. Do you provide any cosmetic procedures/services? Yes No
 If yes, please indicate which procedures.
- | | | |
|--------------------------------------------|-------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Botox | <input type="checkbox"/> Derma Fillers | <input type="checkbox"/> Laser Hair Removal |
| <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Laser Skin Resurfacing | <input type="checkbox"/> Sclerotherapy |
23. Do you perform Deliveries as a midwife? Yes No
 If yes, please answer the following questions:
- A. How many deliveries are performed annually by midwife? _____
- B. Do midwives perform induction/augmentation? Yes No
- C. Do Midwives perform assisted Vaginal Deliveries? Yes No
 If yes, is the physician present? Yes No
- D. Do Midwives perform VBAC deliveries? Yes No
 If yes, is the physician present? Yes No
- E. Do Midwives perform underwater births? 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: _____
24. Describe your procedure for notifying your supervising physician of situations beyond the scope of your training or practice:

25. Please list all states in which you are licensed along with each license number and renewal date:

State	License Number	Renewal Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

26. Please include copies of the following:
- A. Current Curriculum Vitae
 - B. Copy of your approved notification of supervision form
 - C. Copy of current professional liability insurance declarations page
 - D. Claims history
 - E. Copies of your practice protocols

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

Texas and Virginia Purchasing Group Intent to Join

The undersigned insured hereby consents to join the Ob-Gyn Risk Alliance Purchasing Group, a purchasing group formed under the provision of the Liability Risk Retention Act of 1986. One of the purposes of this group is to purchase insurance on a group basis. ProAssurance Indemnity Company, Inc., with its home office located in Birmingham, Alabama, underwrites insurance policies issued for this group and may not be subject to all the rules and regulations of your state.

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.

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